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RHODE ISLAND MEDICAL JOURNAL

JANUARY, 1955

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JANUARY 3-31

The Doctor and His Income Tax
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College of Surgeons Meeting at Providence . . . *See page* 56

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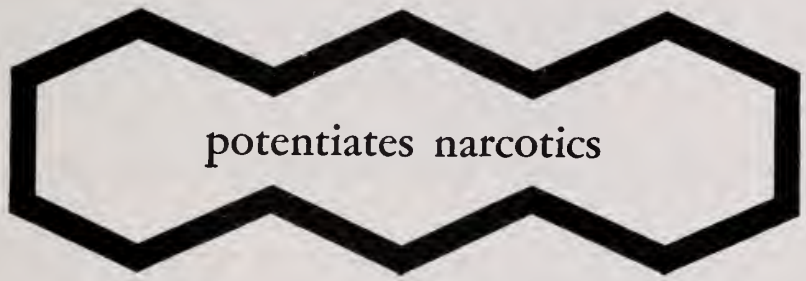
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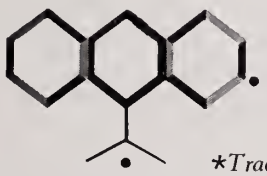
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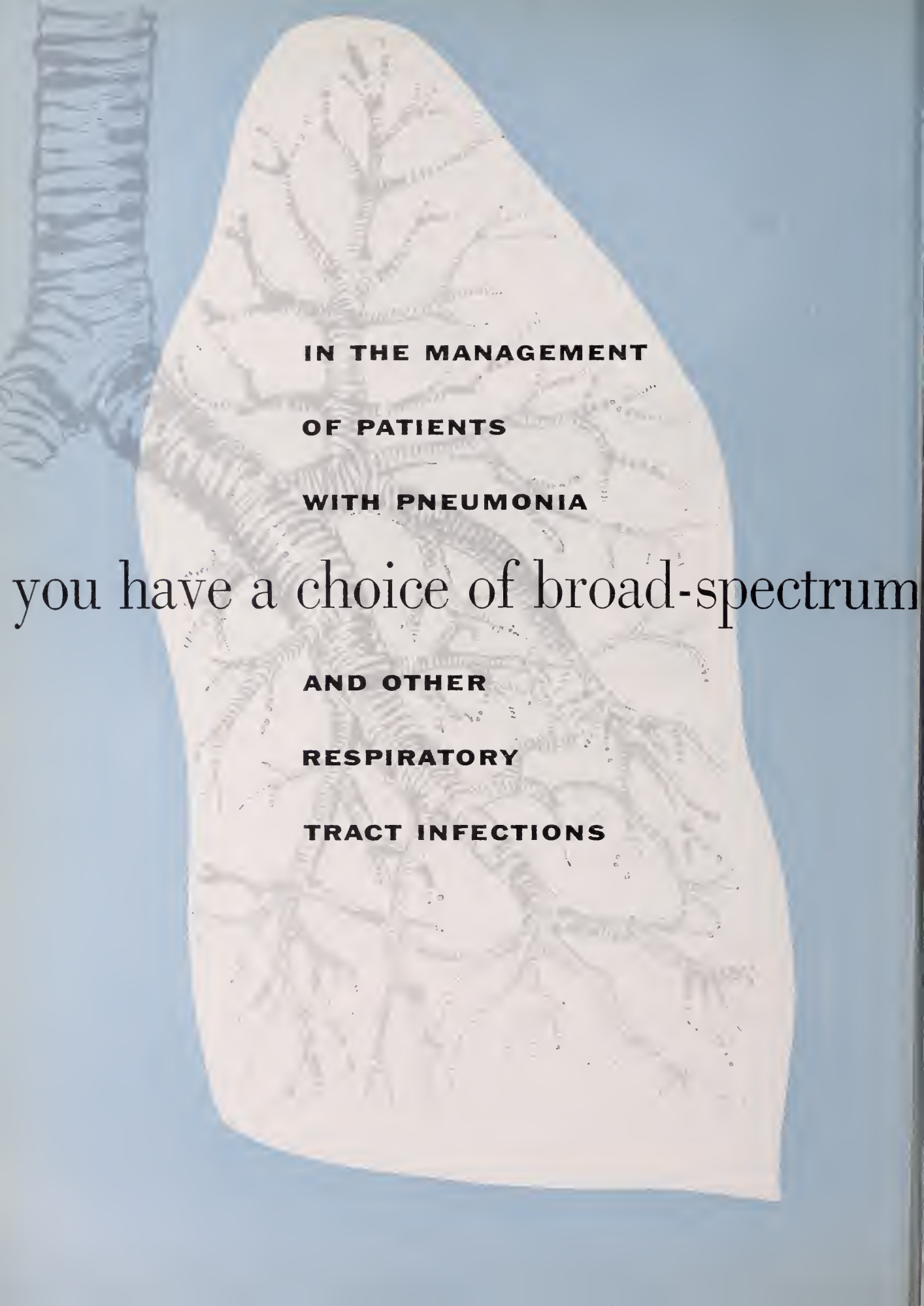
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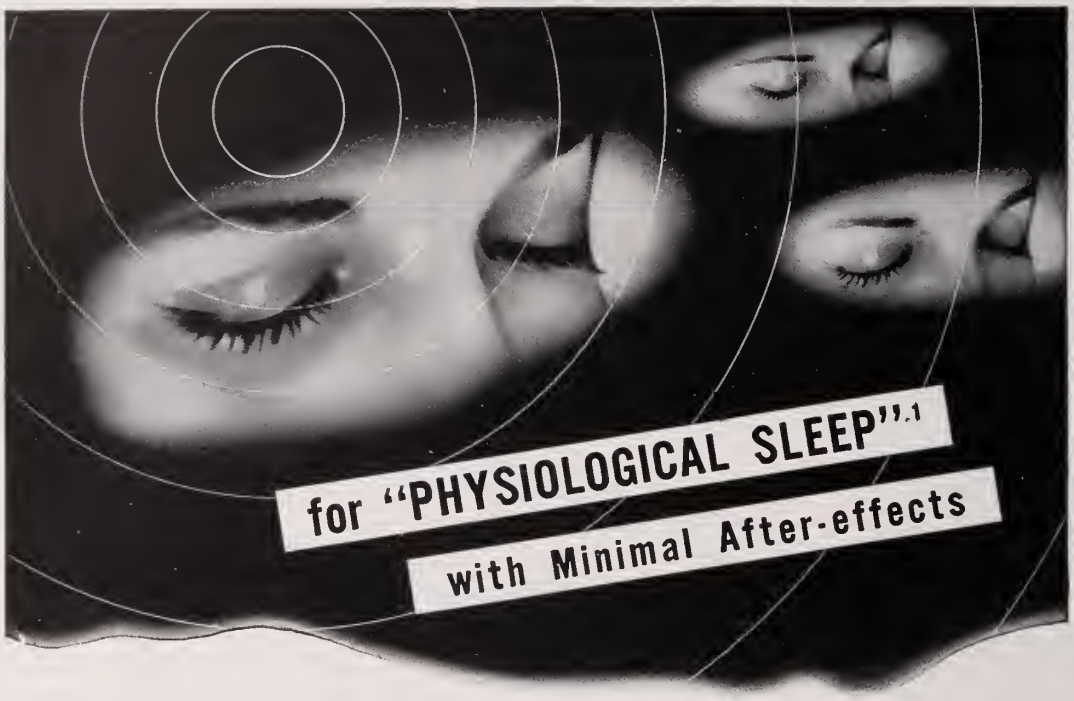
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[1]N.N.R., 1947, p. 398.
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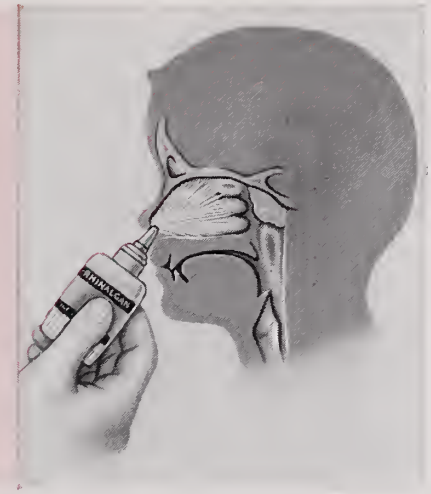
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The RHODE ISLAND MEDICAL JOURNAL

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PLASTIC PLANING OF POST-ACNE SCARS

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POST-ACNE SCARRING and other facial blemishes may profoundly affect the psyche and emotional state of an individual. Far-reaching social and economic disruptions may be the aftermath. The embitterments, frustrations and depressions of those scarred particularly at a critical age are inconceivable to those not similarly afflicted. The facial disfigurements are obvious, but the psychic trauma expressed in an altered and indirect manner is not always apparent to cursory observation.

Any method advanced to remove or render less conspicuous these integumental imperfections warrants consideration. Many procedures have been introduced through the years but dispassionate group appraisal revealed disappointment to physicians and patients alike. More recently, the sandpaper technique of Iverson[1] and later the Kurtin[2] method of plastic planing with revolving steel brushes have given excellent results. I believe the Kurtin method the procedure of choice. Before discussing this procedure, the writer's experience over the last sixteen years will be reviewed.

Results of recommended blistering doses of ultra-violet[3] have been capricious and transitory for scars of long duration but invaluable for diminishing or aborting incipient scars of active acne.

Exfoliation with resorcin or phenol compounds[4] or trichloroacetic acid has produced marked reactions but on subsidence the scars usually remain untouched. Dexterity of technique and sacrifices of the patient have usually gone unrewarded.

The application of CO_2 slush[5] temporarily enjoyed some popularity but proved disappointing after many painstaking trials.

Wallace Marshall[6] reported partial scar absorption with refined experimental liver extract but personal experience with many different liver extracts was without effect in acne or post-acne scars.

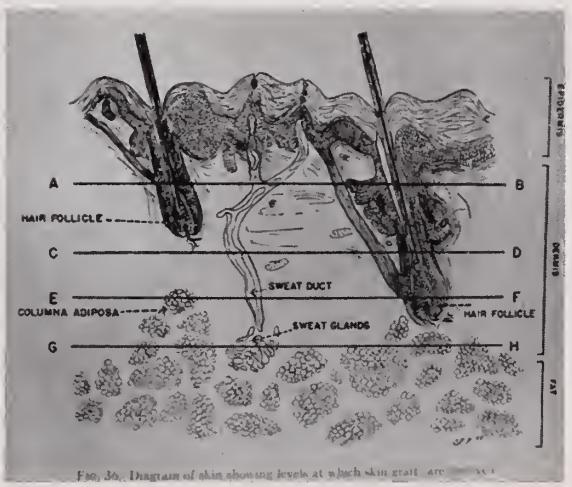
Scarification[7] with a fine needle or scalpel in crisscross fashion after anesthesia with 1% Procaine HCL has been recommended by Gilges, etc. This method is tedious, laborious and lacks the fine control of the Kurtin method.

Employment of monopolar spark gap electrodesiccation[8] to produce destruction of tissue around scar and by so doing produce apparent flattening has afforded improvement in selected cases but newer methods are far superior.

Gratifying and encouraging results have followed fulguration but the patients have been rebellious and unsympathetic to the numerous novocaine injections necessary for anesthesia.

The writer has employed Iverson's sandpaper technique[1] with excellent results but undesirable aspects are: general anesthesia, hospitalization,

continued on next page



Line A-B represents the depth of the Plastic Planing. Diagram used by Dr. Kazanjian in his discussion of skin grafts, and used here with his permission, and Williams and Wilkins, and publishers of Annals of Surgery where it was originally published, page 873, Vol. 120, 1944.

marked bleeding and possibility of silica granuloma formation.

Kurtin's procedure, described in detail in other publications,[2] will be only briefly described.

After surgically preparing the area, a chilled plastic ice pack containing 5% propylene glycol is applied for twenty minutes. Subsequently, while spraying ethyl chloride, a specially constructed air blower is directed to the area to hasten evaporation and thereby enhance the anesthesia and promote rigidity of the skin. The actual planing is then performed with rotary stainless steel wire brushes of various widths mounted on 1/12 HP motor capable of 12,000 r.p.m. After the operation capillary bleeding is controlled by moderate pressure. Healing is usually complete in one to two weeks. Severe cases may require two, three or four treatments.

Rationale of treatment: Many post-acne scars involve to a great extent the epidermis and uppermost part of reticular areas of dermis, although some penetrate much deeper. In general, this would be the equivalent of a Thiersch Graft. Furthermore, it has been observed that the donor area of a skin graft containing epidermis but not including significant depths of reticular layer of dermis has regenerated to full thickness and normal texture without scarring.[9] It is a further observation that regeneration of epidermis takes place from hair follicles and sebaceous glands and that these are particularly numerous on the face. At the time of the operation I have frequently experimented by planing small areas on other parts of the body and found that healing was not only delayed but that the regenerated tissue was not always of normal texture.

Although admittedly the percentage of improvement is difficult to measure it would appear to be fifty to eighty per cent and in selected cases even more.

In addition to my own excellent results, the reports of over 1,000[10,11,12] cases in the literature are most enthusiastic. Some of the advantages of this method may be mentioned:

1. It is an office procedure.
2. The new ethyl chloride procedure obviates the use of general anesthesia or multiple needle injections.
3. There is no silica granuloma formation.
4. When actually performing the operation, the field is bloodless.
5. The use of small steel brushes permits more differential abrasion in selected areas.
6. Patients are not reluctant to undergo repeated treatment when indicated.

More recently Paul LeVan[13] has advanced what he believes to be a more efficient method of ethyl chloride application which consists of a mechanical spraying apparatus. Frederich Riess[14] has written that he finds dental burrs superior to steel brushes.

CONCLUSIONS

After evaluating various modalities for the treatment of post-acne scarring, the superiority of the Kurtin technique has been emphasized. My views are in harmony with the increasingly favorable reports regarding this procedure.

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Before Plastic Planing

After Plastic Planing



Before Plastic Planing



After Plastic Planing



Before Sandpapering



After Sandpapering



Before Plastic Planing



After Plastic Planing

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THE DOCTOR AND HIS INCOME TAX

VICTOR L. PEDORELLA

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CONGRESS on July 29, 1954, passed the 1954 Internal Revenue Code and on August 16, 1954, the President of the United States by his signature enacted it into law. The new code which replaces the 1939 code and all its subsequent amendments is the result of the most colossal change in the history of the Internal Revenue Code. It not only effected changes which caused taxpayers undue hardships but also made many major changes with respect to administration and procedure in collecting the Federal Income tax.

The revenue effect of the new code for the fiscal year 1955, has been a reduction in individual income tax of approximately $800,000,000.00, and a corporate tax reduction of approximately $620,000,000.00. However, this total loss in revenue of $1,420,000,000.00, has been offset by the increase in revenue of $1,200,000,000.00, arising from the extension to April 1, 1955 of the present 52% corporation income tax rate which was due to expire on April 1, 1954. The net result of the enactment of the 1954 code is a loss in revenue of approximately $220,000,000.00.

The reason for the 1954 code is best expressed in the report of the House Ways and Means Committee which stated "Your Committee has undertaken the most comprehensive revision of the Internal Revenue Law since before the turn of the century and the enactment of the Income Tax." This revision includes a rearrangement of previous laws to place them in a more logical sequence, the deletion of obsolete material and an attempt to express the Internal Revenue Laws in a more understandable manner.

Because of the numerous changes made by the new code, an attempt to cover the subject at hand in one article would not only be too lengthy but it would also result in heavy and tiresome reading. I intend to cover the subject in two articles beginning with this current issue and ending with that for the month of February, as follows:

(1) Changes affecting the individual taxpayer which include all members of the medical profession and

(2) Professional income and expenditures of the medical practitioner reported on Schedule C of the return. I also intend to add my comments regarding errors which in some cases result in the doctor overpaying his tax, and in others are the direct cause of the return being selected for a field examination which not only entails added expense but also involves loss of the doctor's valuable time even though no deficiency is disclosed.

Income Tax Rates

The income tax rates for individuals are the same for 1954 as they were in 1953, except that the new code has combined the 3% normal and surtax (by brackets) into one. In computing tax for 1954 the Internal Revenue Service is using the same rate schedule it used in 1953.

Requirement for filing returns

Under prior law a return was required by all individuals who had gross income of $600.00 or more during the taxable year. This has been continued in the new code for all taxpayers, whether blind or not except it provides that a taxpayer who has attained age 65, before the close of the taxable year will not be required to file a return if his or her gross income during the year was less than $1,200.00. Many aged taxpayers who had less than $1,200.00 gross income during the year were required under prior law to file returns if 65 years of age or more, which was really a futile gesture since there was no tax due, because of being allowed two exemptions of $600.00, one as a taxpayer and one for being 65 years of age or more.

Due date of the return

The due date of the return has been extended from March 15th to April 15th, which allows a taxpayer an additional month in which to file his return. Although this extension is warranted, mere procrastination in filing the return usually results

in undue hardship to the spouse and family of the taxpayer especially in those cases where the taxpayer is suddenly seized with a serious illness, accident, and in many cases death. I have encountered many cases in my years of service in the Internal Revenue Department, in which the taxpayer was the only person who could furnish the necessary data both with respect to his professional and private income and expenditures, which necessitated requests for more than one extension. Where an extension is desired it will be necessary to submit a letter to the District Director of Internal Revenue explaining the reason for the request, which letter must be in his office on or before the due date of the return, and if granted the taxpayer will in turn receive an original and duplicate letter from the director. When the return is finally filed, the original of the letter granting the request should be attached to the return which will eliminate the erroneous assessment of any penalties for late filing.

With respect to extensions, an interest charge of 6% of the tax shown on the return is assessed against the taxpayer, from the due date of the return to date the return is received by the director. A taxpayer who wishes to avoid this interest charge is permitted to submit a check in the amount of the tax he thinks will be due with the extension request letter. The new code provides that no interest will be paid as refunds of tax overpaid until the expiration of forty-five days after the due date of the return. Under prior law, interest of 6% was paid on refunds mailed to the taxpayers after March 15th.

Splitting of Income

Married persons who file joint returns were permitted under the old law to split income, which permitted such taxpayers to divide the taxable income by two, compute the tax and then multiply the tax so computed by two which resulted in computation of tax at the lower bracket rate. The new code has made no change in this respect with married people who file a joint return, except that it now provides that a widow or widower may compute his or her tax by the splitting of income method for the next two years following the death of the spouse, providing that such widow or widower has not remarried during the taxable year and has furnished over one-half support to a dependent, son, stepson, daughter, or stepdaughter whose principal home was that of the surviving spouse. This new law will apply to all such surviving spouses even though their spouse died in 1952, or 1953, provided that the spouses were permitted to file joint returns in the year of the spouse's death even though separate returns may have been filed. Thus:

Spouse died	*Dependent child*	*Re-married*	*Year's tax may be computed by splitting income*
1952	yes	no	1954
1953	yes	no	1954-1955
1954	yes	no	1955-1956

It must be explained that under both the old and new codes, a surviving spouse who has not remarried may file a joint return in the year in which his or her spouse died.

The provision of this section of the law limits this benefit only to surviving spouses who file their returns on Form 1040.

Dependents (new groups added)

Although the 1954 code has made radical changes with respect to the dependency deduction by the addition of two new groups to the list of those who may be claimed as dependents, it has not changed the fundamental rule that a taxpayer in order to claim any of the following listed below must show that he or she furnished over one-half support and such dependent did not have gross income of $600.00 or more during the calendar year in which his taxable year began:

(1) son, stepson, daughter, stepdaughter, or their descendants
(2) brother, stepbrother, sister, or stepsister of the taxpayer
(3) father, mother, or either of their ancestors
(4) stepfather, stepmother of the taxpayer
(5) son or daughter of a brother, or sister of the taxpayer
(6) brother or sister of taxpayer's mother or father and
(7) the in-laws of the taxpayer (divorce does not wipe out the relationship for the dependency deductions purposes)

Permits dependency deduction for non-relatives and cousins

The new code has added the following group who may be claimed as dependents providing such dependents do not have gross income of $600.00 or more, and were furnished over one-half support by the taxpayer during the year:

(1) *Any individual, who though not related to the taxpayer* has lived in the taxpayer's household during the *full calendar year* as a member of such taxpayer's household. The individual may be away from the household of the taxpayer for either schooling, illness, or military duty. The old code caused undue hardship to the taxpayer who maintained in his household a non-relative, in that irrespective of the amount spent for such individual's support, the taxpayer could not claim the credit. This section also covers those taxpayers who have taken for adoption purposes state wards who under

continued on next page

the old code could not be claimed as dependents until the year in which the legal adoption took place. Under the new code the taxpayer would be entitled to claim the $600.00 deduction, if the child has lived in his household during all of his taxable year, irrespective of the fact that legal adoption had not taken place before the close of the taxable year.

Under this provision of the code a cousin who qualifies as a dependent may also be claimed, whereas under the old code a cousin could not be claimed as a dependent regardless of whether he was totally dependent on the taxpayer or not; the cousin so claimed must live in the taxpayer's household for the full taxable year. Examples:

(1) Dr. William Burden and his wife Mary, filed a joint return for the calendar year 1954, and during the full year there lived in their household Miss Jane Brill, age 60. Miss Brill had gross income of $350.00, and during the year she was furnished over one-half her support by Dr. Burden. Under the new code, Dr. Burden could claim the dependency deduction of $600.00 for Miss Brill on his return even though she was not related either to him or his wife.

(2) Dr. and Mrs. John Salk were childless, but on December 10th, 1953, they selected a child four years of age from the State Home and School for the purposes of adoption. The state law provided a probationary period of eighteen months before Dr. and Mrs. Salk could legally adopt the child. Dr. and Mrs. Salk would be permitted to claim the dependency deduction of the child on their 1954 return even though legal adoption would not be effected until 1955.

The new code further provides that a cousin who was furnished over one-half support, and did not have gross income of $600.00 or more during the calendar year of 1954, may be claimed as a dependent if such person was receiving institutional care because of some physical or mental disability, providing that he or she was a member of the taxpayer's household before such confinement. It is noted that this provision differs somewhat with (1) above which requires that the non-related individual, which includes a cousin, must live in the taxpayer's household for the full year. Example:

Dr. James Burrows furnished full support to his cousin during 1954. The cousin had lived with Dr. Burrows since 1947. On March 10, 1954, his cousin was removed to the State Hospital because of his physical condition. Dr. Burrows would be entitled to the dependency deduction on his 1954 return, if there is no subsequent change in the code in this respect. Dr. Burrows would be entitled to the deduction for 1955 because the cousin before being confined in 1954, was a member of his household.

Permits dependency deduction for children having gross income of $600.00 or more

Under prior law, a parent could not claim the dependency credit for a son, stepson, daughter, or stepdaughter if such child had income of $600.00 or more during the taxable year. This caused financial hardship to those parents who had in many cases furnished additional money during the year for their attendance at a preparatory, junior college or an educational institution of higher learning. Many parents whose children had earned exactly $600.00 during the year were prohibited from claiming the dependency credit, resulting in an added tax burden of approximately $130.00 if in lower brackets (considerably more in higher tax bracket). It can be easily understood that if the son or daughter had earned $599.99 the parent would have been permitted to claim the dependency credit.

The new code has rectified this injustice to parent taxpayers, and has provided that a parent who has furnished one-half support for his child during the taxable year, may claim the dependency deduction even though such child has gross income of $600.00 or more during the taxable year provided:

(1) That the child had not attained nineteen years of age before the close of the taxable year or

(2) the child, if over nineteen years of age during the taxable year, was a full-time student of an educational institution for each of *any five months* of the calendar year in which the taxpayer's taxable year begins.

One day or more of any month that the child was a student is computed as a full month in determining the "any five month" qualification. The value of a scholarship, if any, is not taken into consideration in determining support.

It is my opinion that when the regulations for the new code are issued, one who attends night school and works during the day will not qualify as a full-time student.

The term "educational institution" is defined as a school maintaining a regular established faculty, study programs, and normally has a regular organized body of students (grammar, high, preparatory, junior college or university). It does not include non-educational institutions, correspondence schools, and on-the-job training programs. Examples:

(1) Dr. Henry Willis furnished over one-half support during 1954, to his son Henry, age seventeen. Henry attended high school from January 1 to May 10, 1954 (four months), and earned for the remainder of

the year $900.00. Dr. Willis would be entitled to claim the dependency credit for his son because he was under nineteen years of age. If Henry had attained twenty years of age in 1954, then he would not qualify as a dependent of his father, because he had not attended school as a full-time student for any five months of the taxable year.

(2) Dr. William Sears' son William, twenty-five years of age, was a student at Jefferson Medical School in Philadelphia for nine months of 1954. William received a scholarship valued at $1000.00 for 1954. During vacation period, William worked at the Presbyterian Hospital earning $560.00; in addition, he had interest on a savings account of $100.00. Dr. Sears' furnished William $400.00 for expenses and $300.00 for clothes. Dr. Sears would be permitted to claim the dependency credit, since his son qualified as a student and the doctor had furnished $700.00 for his support which was over one-half of $1,360.00 necessary for William's support which included his earnings of $560.00, and interest received of $100.00. If the value of the scholarship was taken into consideration in determining support, Dr. Sears would not have furnished over one-half of William's support. The new law provides that the value of a scholarship is not to be taken into consideration in determining support of a dependent.

Multiple support agreement regarding dependents

The new code provides a new concept for claiming dependency deductions in those instances where two or more related taxpayers furnished support to one whom they could claim as a dependent under the law. It provides where two or more taxpayers furnished such support during the year:

(1) Only the taxpayer who contributed over one-half support during the year may claim the dependency deduction *or*

(2) An election may be made by those taxpayers who furnished support to the dependent providing that no one single taxpayer contributed over one-half of such support and no one contributed 10% or less of such support.

(3) Where an election is made as explained in (2) above a written statement, the form of which is in preparation by the Secretary of the Treasury must be signed by those who did not elect to claim the dependency deduction. With respect to those who did not contribute over 10% of the support required for the dependent, no statement is necessary since the deduction is not permitted of those individuals as follows:

(1) Three brothers *A*, *B*, and *C* furnished support to their dependent brother *D* during 1954 who did not have any gross income whatsoever as follows:

A contributed	$ 580.00
B contributed	360.00
C contributed	210.00
Total	$1,150.00

Since *A* contributed over one-half of $1,150.00 there is no election, *A* is the only one who is permitted the deduction.

(2) Assume in (1) above that

A contributed	$ 590.00
B contributed	210.00
C contributed	380.00
Total	$1,180.00

Since none of the brothers individually contributed over one-half support, either may claim the deduction.

(3) Assume in (1) above

A contributed	$ 590.00
B contributed	580.00
C contributed	120.00
Total	$1,290.00

In this case either *A* or *B* may claim the deduction but *C* is not considered since he did not contribute over 10% of the $1,290.00.

Annuities

Under prior law an annuitant was required to report 3% of the cost of an annuity as taxable income, the balance of the amount received was deemed to be recovery of cost after which the annuity payment was taxable in full.

Under the new code an annuitant must determine the expected return from the annuity. When it is payable for a specified number of years the expected return would be the annual annuity payments multiplied by the number of payments called for under the contract whereas if the annuity provided for life payments it would be necessary to refer to the life expectancy table and multiply the life expectancy by the annual payments to be received as follows:

(1) On Jan. 7, 1954, an annuity matured which Dr. William Williams, age 55, purchased in 1934. It cost him $30,000.00 and was to pay him $4,000.00 annually for 10 years beginning Jan. 8, 1954. The portion of each annuity payment that is excluded from taxes (return of capital) is determined by arriving at his expected return from the

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HISTORY TAKING IN ALLERGIC DISEASES*

(With Special Emphasis on Childhood Asthma)

STANLEY S. FREEDMAN, M.D.

The Author. *Stanley S. Freedman, M.D., of Providence, Rhode Island. Associate Physician, Department of Pediatrics, Rhode Island Hospital.*

AMONG the many procedures available for the diagnosis and management of allergic diseases, first and foremost is a thorough and complete history. There are other diagnostic procedures such as skin testing, eosinophile counts, x-ray examination and vital capacity measurements, but these will contribute much less to the total understanding of a case of allergy, than would a good history.

An allergic history does not end with the first interview. As the patient is observed and additional facts become known, the history will be augmented accordingly, and so will be the management of the patient. Chart 1 may be used as a guide when taking an allergic history.

Family History

The family history is of importance, as it may provide information on prognosis. A bilateral family history of allergy may indicate a stormy course. Where there are several non-allergic siblings in the family, one may feel relieved. Whereas if there are no siblings as yet, one wonders whether future siblings will or will not also have allergic disease.

Past History

Infantile colic, regurgitations, vomiting, frequent formula changes, and other past abnormal gastrointestinal manifestations may indicate food allergy, especially milk allergy. A history of foul, bulky, greasy stools, in infancy, requires that we rule out cystic fibrosis of the pancreas, which in later childhood may simulate bronchial asthma.

Frequent bouts of sniffling, rhinorrhea, and colds in infancy and in childhood, are often early manifestations of respiratory allergy. What we often consider upper respiratory infections may be and often are upper respiratory bouts of allergy, masked by concomitant infection. Attacks of the croup often precede clinical asthma.

*Read at the New England Pediatric Society Session in Providence, R. I., May 12, 1954.

From the Rhode Island Hospital Pediatric Allergy Clinic.

Onset

The age of onset of asthma is significant. Dr. William Buffum[2] has called attention to the fact that often bronchial asthma begins in the first year of life. If so, it is likely to run a severe course. 19% of the 250 patients of Buffum's series had symptoms during the first year of life. The circumstances leading up to the first attack of asthma are important. If a respiratory infection accompanies the first attack, one may assume that similar future respiratory infections will likewise initiate or predispose to more asthma. If the first attack followed a visit to the zoo, it implies that animal dander is at fault. The season of the year when the first attack occurred should be checked with the prevailing pollen or mold season. One should remember however, that more than one season is required for the clinical diagnosis of seasonal allergy.

When asthma follows pertussis or pneumonia, and if symptoms and physical signs continue, one should keep in mind the possibility of coexisting bronchiectasis. In 160 cases of bronchiectasis studied, Field[1] found that pertussis and pneumonia are the commonest predisposing diseases in childhood. Therefore it is logical to assume that in some cases where asthma followed pertussis or pneumonia, and especially if the asthma is not easily controlled, early bronchiectasis may be a complicating factor.

Frequency and Duration of Attacks

When a child has only one or two attacks per year, it is very likely due to a respiratory infection. If attacks occur frequently the etiologic mechanisms may be numerous and complicated. It is well to note the duration of the attacks. Brief wheezy spells will respond to almost all types of simple medications. Long drawn out attacks will require careful planning and complicated treatments. A special effort should be made to ascertain the patient's status between attacks. When a child wheezes continually even between attacks, we may suspect a foreign body or a congenital anomaly. Fibro-cystic disease of the pancreas may be present and should be ruled out. Last but not least, a common environmental allergen may be the cause of continuous wheezing. The same may be said about food allergens.

Season

Of greatest importance is the repeated annual seasonal incidents or flare-ups of allergic manifestations. The discovery by Noon of England, in the early part of this century, of the relationship between seasonal pollination of certain plants with clinical seasonal hay fever and asthma is a bright chapter in the history of allergy. Many patients make their own diagnosis when they discover that their allergies appear the same season year after year. It is difficult for most patients to remember specific dates, but they may recall holidays during which time their symptoms occurred.

Chart 2 shows the pollination seasons of the important hay fever producing plants in this area. A house dust season is included, although it is by no means as definite as the pollen seasons. Many authors believe it exists in early fall, corresponding to the time when the human family turns on the heating system and goes inside. The radiating heat refloats all kinds of allergenic particles into the air, which during the summer months settled undisturbed in crevices, corners, and similar other places.

There are two (2) types of seasonal allergic manifestations:

1. *Purely seasonal hay fever or asthma.* Symptoms are confined to the time when the specific disease producing pollens are in the air. The symptoms subside with the disappearance of these pollens from the atmosphere. Here the diagnosis is made without difficulty, especially after the first or after the second year of the disease.

2. *Perennial symptoms with seasonal flare-ups.* In this instance, a patient has symptoms all year round, but in addition there are distinct seasonal flare-ups. The seasonal character may be overlooked, unless the physician keeps this possibility in mind. In this situation a positive skin test is of great value and is often a decisive factor in establishing the fact that a seasonal pollen or mold is associated with the seasonal flare-ups. (See chart 2.)

Known Sensitivities

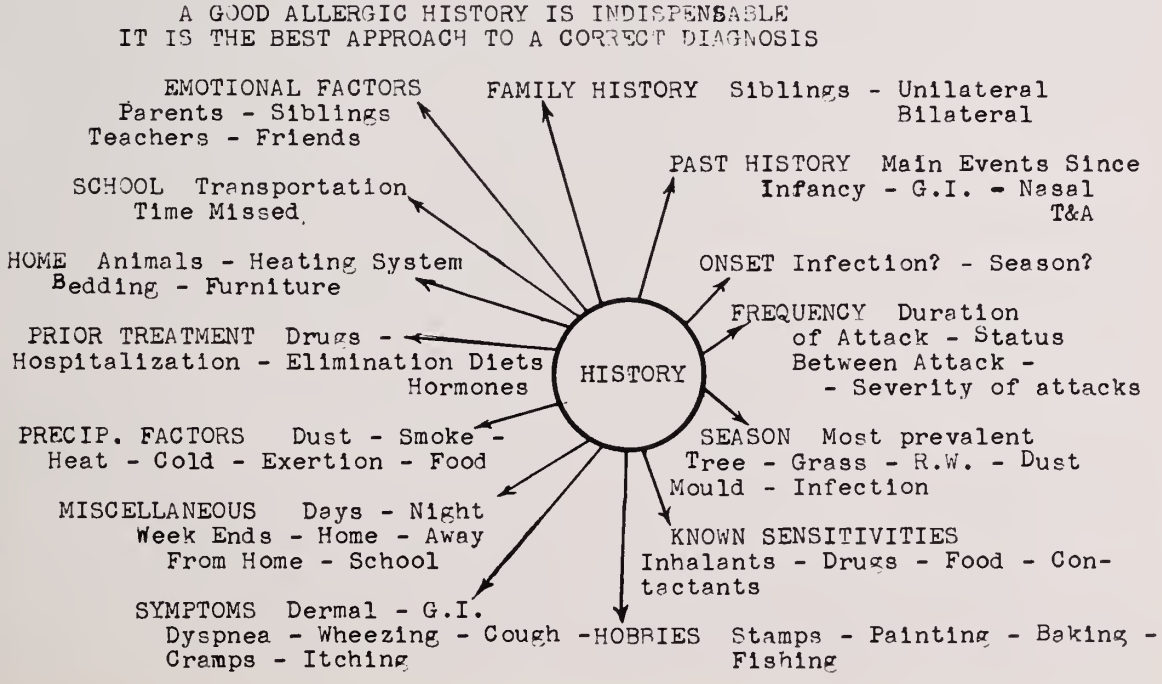
Patients or parents frequently are aware of one or more items in the diet or in the environment which they think are capable of provoking symptoms. These suspected provocators should be listed, and should be verified, or disproven. Otherwise the patient may be denied a food or some worthwhile object unjustly, or may be exposed to or given something to which sensitivity exists. Drugs and biologicals which have previously been given should be listed and their reactions noted if any.

Hobbies

The hobbies of an asthmatic patient may profoundly influence the course of the disease. Fish glue sensitivity would not permit an asthmatic patient to become a stamp collector. It is not yet known whether paint and turpentine are truly allergenic, or whether they act as respiratory irritants. However, many asthmatic patients will wheeze

continued on next page

Chart 1, Showing Salient Features of an Allergic History



when exposed to the odor of fresh paint, and these patients find it necessary to completely avoid paint.

The importance of wheat flour as an inhalant allergen is often overlooked. The child who helps her mother with her baking, the child whose father is a baker, or the child who lives above a bakery is abundantly exposed to raw flour. Fish and shellfish may be allergenic, either as ingestants or as inhalants. The four-year-old son of a Providence surgeon, who is exquisitely allergic to a variety of foods, and whose asthma is under control developed intense wheezing and choking when he came in contact with small live crabs on the beach near his summer home. If this fact were not known to the parents, the boy might have been given crab meat to eat with possible catastrophic results.

Symptomatology

It is desirable to obtain a detailed description of the symptoms during an attack of asthma. Such a description may clarify the diagnosis of asthma when it is in doubt. It will aid in the planning of the treatment of acute episodes. If attacks are characterized chiefly by dyspnea and wheezing a broncho-dilator drug such as ephedrine, in combination with a sedative, is all that may be needed. If these symptoms are severe, adrenalin may be given every half hour. Children often have violent gastrointestinal upsets which accompany the attack of asthma. If so, subcutaneous adrenalin or rectal aminophyllin may be the answer.

When severe coughing accompanies the attack, we should note whether it is a productive cough. If so, what is the nature of the secretions? If thick and tenacious, iodides or terpin hydrate should be included in the early treatment of the attack. Not infrequently during an attack of acute asthma, secretions are so copious and so thick that the patient is unable to cope with the situation. This is a most critical stage in acute asthma. At this point air is prevented from entering the terminal bronchi because of the obstructive secretions. Whatever air does enter the lungs is retained by virtue of the existing mucosal edema and bronchospasm. Residual air volume and intrapulmonary pressure is increased. Tidal air is diminished. The patient will soon be exhausted. This is probably the only time when the very life of an asthmatic patient may be in danger.

When the history reveals that prior attacks reached the stages just described, then we should be prepared for prompt heroic medical treatment, including the use of aminophyllin, iodides, and ACTH intravenously. Sometimes bronchoscopy under general anesthesia has to be resorted to.

If elevated temperature is the rule in many of the previous attacks, we may assume that respiratory infection is a major trigger. Cyanosis in bronchial asthma is a grave symptom. If present it presents an indication for the use of oxygen. There may be other symptoms, which if listed while the history is taken, will enhance our understanding of the case.

CHART 2

Showing the Pollination Seasons in the R. I. Area, Also a Probable House Dust Season

	Species	*Pollination Time*
Trees	Maple	March, April
	Birch	May
	Oak	May
Grasses	Timothy	June, July
	Orchard Grass	June, July
	June Grass	June, July, August
Ragweed	Short R.W.	August, September, October
	Giant R.W.	August, September, October
Household Dust		October, November, December

Precipitating Factors

Patients or parents often know or think they know one or more items that are predisposing to an attack. It may be a food, an animal, a hay ride, exertion, or a particular climate. These items represent clinical causes of asthma. Although we cannot always demonstrate their importance immunologically, we cannot ignore them either. In the case of a suspected food, an effort should be made to verify its clinical importance, and if so to avoid it. If, however, it is shown by trial diets that it has no clinical importance, the child should not be deprived of it. Needless to say, every predisposing factor should be eliminated.

The Home

Domestic animals, feather pillows, old or antique overstuffed furniture, stuffed toys, and many other household articles make up the house dust, which is highly allergenic to a large percentage of asthmatic patients. Fumes from the kitchen oil stove may be the causative agent in certain cases of asthma. Molds or dampness from a poorly ventilated cellar may also be a factor. Frequently it will be of help for the physician personally to visit the home, in order to make a direct inspection of the patient's immediate surroundings.

School

The actual number of school days missed per given period of time is a fair index of the extent of the child's asthma. Occasionally a youngster experiences an excessive amount of asthma in the school room. Presumably the blackboard chalk dust may be a factor. The child who has to walk a long distance may arrive at school with wheezy respiration caused by exertion. He may thus have a poor day at school. By providing transportation, preferably in the family car, the child will enter his classroom in a much better condition to assume

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THE CHALLENGE TO MEDICAL EDUCATION

THE FUTURE of this nation depends upon the development and preservation of its resources. Of these, there is nothing more vital than the health of its citizens. To preserve this priceless possession by preventive and therapeutic measures is the function of the medical profession. Even as the efforts of the profession become more effective year by year, and the level of general health and longevity of the people is increased, so also do these efforts become, of necessity, more complicated and more expensive. In the same way, it takes progressively more time and effort, and more money to train a young physician to the necessary level of competence in the application of these measures. In other words, the cost of medical education progressively goes up, but the private sources of financial support of such education do not.

In Public Affairs Pamphlet, No. 214,* under the above title, "The Challenge to Medical Education," Robert M. Cunningham, Jr., for nine years Editor of MODERN HOSPITAL, has ably summarized the situation. He states that "the doctors who provide our medical care are a national resource of surpassing importance," and then goes on to show that the maintenance of the supply of these doctors is gravely threatened by a lack of financial support. This, of course, is no news to physicians generally, who, as pointed out in the pamphlet, have been contributing generously, either through the American Medical Education Foundation or by direct contributions to the medical schools where each was trained. Businessmen and industrialists have given their support through the National Fund for Medical Education. But, as Mr. Cunningham remarks, "The $7,000,000 provided so far by business and the medical profession . . . is no more than a strong beginning toward a real solution to the financial problems of our medical schools." It appears certain that these sources alone cannot make up the difference between the $3,000 to $4,500 a year it costs to educate a medical student and the $600 to $900 a year that he pays in tuition. To put it simply, we need more doctors, who must be educated at increasing cost, and the money to support this essential need is not forthcoming. As stated in pamphlet 214, "Plainly, more and more groups

*Public Affairs Pamphlets, 22 East 38th Street, New York 16, N. Y.

continued on next page

must accept an increased share of responsibility for support of medical education if we expect the schools to perform fully and effectively in the future."

The obvious alternative is complete government financing, which means political control. It occurs to us that the pharmaceutical industry, whose work is necessarily so closely connected with that of the medical profession, might well save most of the money spent in very expensive illustrated brochures and similar material, by which each firm seeks to "educate" the practitioner to use its particular products, and could well turn such funds over to be used in the fundamental educational processes of the medical schools and hospitals. Such contributions could, and should receive full credit, and would constitute the most effective and ethical advertising to the firms which so contribute, while making a real move in support of the work on which the welfare of these firms as well as the health of the public depends. This may be one of many sources of support that must be tapped if medical education in this country is to remain free and to progress.

THE DOCTOR AND HIS INCOME TAX

In this issue we publish the first of two articles on the effect of the new Internal Revenue Code upon the physician as an individual taxpayer. The second article which is scheduled for our next issue will deal with the problems the physician faces in resolving his federal taxes in his work as a medical practitioner.

Written by an accountant with more than two decades of service locally with the department of internal revenue of the Federal government, the articles bring to our membership authoritative and informative presentations that should be most helpful.

Taxation questions at their simplest form are vexing, and we are sure that Mr. Pedorella has found a way to clarify the new provisions of the 1954 code that will prove lucid to every taxpayer in our membership.

GONE AT SIXTY

When automobiles first started to speed along our roads we recall that the expression of that day was that a person was "going like sixty."

Recently, we read in the daily press that a congressman from one of our neighboring states plans to introduce in the Congress of the United States this year a bill to reduce the retirement age under the social security system to sixty years. We daresay that his proposal will not be the only such vote getting one of this type to be introduced. Thus it would appear that our legislators will soon have us "gone by sixty."

The fear of insecurity that has arisen in recent years is now beginning to have its ramifications upon the industrial pattern of the country, as well as upon the individual citizen. People have lost confidence in opportunity, and in themselves. The answer, contrary to what federal legislators may believe, is definitely not in programs calling for what amounts to compulsory retirement at the age 60.

Within a week of the announcement of our congressional member that he would seek a lower retirement age, the press carried the warning of Secretary of Labor Mitchell based on a year long Labor Department study that

> **Unless something is done to give them (the adult population) job opportunities, an estimated half of our adult population will be condemned to a life of economic uselessness.**

The Labor Department study pointed out that unless prejudices about hiring older workers are quickly overcome half the nation's adult population will be jobless twenty years hence. Most of the objections to hiring older workers are mere facies, the department stated, for in truth their performance is equal or superior to younger workers, their judgment is better, and they have better safety and attendance records.

In urging the medical profession, and particularly the medical directors of life insurance companies, to fight the widespread retirement at the arbitrary age of 65, Dr. Karl W. Anderson, chairman of the medical section of the American Life Convention, told that group last summer

> "The Government in its attitude towards social security is at least suggesting, and many times forcing, a premature retirement. The original idea of social security—to keep people away from the poorhouse—has been lost sight of and somehow the idea has crept in that social security is an adjunct to retirement funds. So now to enjoy this luxury it is necessary for people to lay down their tools and let their skills grow rusty starting at the age 65 (and at age 60, according to the new proposals). Time and social security experience itself are proving how wrong this concept was. The average age at which American citizens claim their first social security pension check is 69!"

Predicting that the United States Government will eventually have to reverse its attitude toward retirement, Dr. Anderson stated "I do not believe the lengthening life span and the growing population of people living beyond the age of 65 will permit even the world's most productive nation to support economically a system in which so large a percentage of its members are totally unproductive and therefore totally dependent. We must encourage people to continue work for economic reasons as well as for their own happiness."

The viewpoint of the physician meeting the older

age person in his daily practice was ably set forth recently by Dr. Charles Sellers in an editorial in the DETROIT MEDICAL NEWS on *The Tragedy of Retirement* in which he points out that

"Physicians are in an exceptionally unique position in that they are not forced to retire but may decrease the work load without losing contact with medicine and doctors. Illness may be the only exception and many ill physicians continue some activities because they love their work.

Retirement is rejection.

Rejection is devastating, both psychologically and sociologically. It decreases one's statute, deflates one's ego . . . (and) to be "put on the shelf" intimates uselessness and few of us would accept such an appraisal willingly. . . .

Retirement is not the rosy Nirvana that some hard-working persons envision it to be. After a few weeks or a few months, it becomes a dreary existence that gradually becomes more and more detached from the rest of the work-a-day world. . . ."

What is needed is less planning by legislators on how to make people prematurely idle, and more planning for old age security on a healthy basis, with a sober evaluation of our existing realities and an intelligent approach to the transition to a sound and healthful concept of retirement.

SURGICAL MEETING FOR ALL DOCTORS

In this issue you will find the program of the Sectional Meeting of the American College of Surgeons to be held here on March 3-5, and the College wishes us to emphasize that *all our members* are invited. We think that it would be a smart thing for everyone to go, even those not surgeons. The modern surgical meeting is a very different thing from what it was not too many years ago. It is not taken up with the details of operations and descriptions of new techniques. Any medical man should get much out of many of these papers.

In fact, the old division of medical and surgical is rapidly becoming obsolete. No case is in either category until it has been studied. Every surgical case needs a great deal of medicine (not drugs, but the careful study that a good internist gives his cases).

You will hear a great deal of physiology discussed by some surgeons who are excellent physiologists. The last Sectional Surgical Meeting here was a great success. This one evidently will be the same.

***YOU* ARE INVITED . . .**

See pages 56, 57, 58

HISTORY TAKING IN ALLERGIC DISEASES

concluded from page 30

his school duties unhindered by his physical handicap. In some communities the Red Cross will provide such transportation.

Miscellaneous

We should find out whether a patient is worse during the day or during the night. By far too many patients find their asthma more threatening during the hours of the night. The reason is not known. Is it the temperature which is at fault? Is it due to common environmental allergens which have not been brought under control? Perhaps it is related to the physiology of fatigue. When a patient is experiencing more difficulty on week ends, one will inquire how the patient's habits and activities differ on week ends from those on week days. Is the patient better when away from home? If so we may again ponder over house situations.

Emotional Factors

An allergic history is not complete without surveying the emotional background of the patient. An attempt should be made to determine if the child is properly adjusted at home, and at school. Is the child under stress or tension? Naturally a happy, serene home is essential for a child plagued with bronchial asthma.

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CHECK MARCH 7

The Doctor's Retirement Problem

will be discussed at the meeting of the

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THE DOCTOR AND HIS INCOME TAX

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annuity which is $40,000.00 (10 payments multiplied by $4,000.00) as follows:

Amount received each year	$4,000.00
30,000.00 / 40,000.00 × 4,000.00	3,000.00
Taxable in full each year	$1,000.00

(2) If the annuity provided for life payments then the expected return would be determined by the life expectancy of Dr. Williams at age 65. Assuming in the above that all the facts are the same except that it provided for life payments and Dr. Williams' life expectancy was 15 years by reference to the life table, the expected return would be $60,000.00 and the amount of each payment excluded would be determined as follows:

Amount received each year	$4,000.00
30,000.00 / 60,000.00 × 4,000.00	2,000.00
Taxable in full each year	$2,000.00

If Dr. Williams outlived his life expectancy he would still be required to pay tax on $2,000.00 of each annual payment.

Endowment policies

Where an endowment policy matures during the year the difference between the cost of the policy and the amount payable at maturity is taxable except that the difference may (taxpayer's option) be allocated one-third in the year of maturity and one-third may be allocated to each of the two preceding taxable years. Example:

Dr. Henry Brown in 1933, purchased an endowment policy which cost him $16,500.00, and July 7, 1954, it matured, Dr. Brown was paid $19,800.00. He could elect to allocate the excess of $3,300.00, in his returns of the years 1954, 1953 and 1952. This method would probably result in a tax savings for Dr. Brown in that it would reduce his tax bracket. There would be no need to file amended returns for 1952 and 1953. Dr. Brown could recompute his tax for 1952, and 1953, by attaching a statement to his 1954 return and adding the additional tax computed with respect to each of the years 1952 and 1953 to the 1954 tax.

Life Insurance

The proceeds of life insurance received by a beneficiary because of death of the insured were not taxable under the old law and are treated in the same manner under the new code. Where the beneficiary leaves the proceeds with the company, and is paid interest the payment is taxable in full as interest received.

Where insured dies after Aug. 16, 1954

Where the proceeds are left with the company (option by insured or beneficiary) with provision that the annual payments be made either over a fixed number of years or for life, such payments are treated the same as annuity. The cost basis will be the proceeds of the life insurance except that a surviving spouse may exclude an additional $1,000.00 from the amount subject to tax each year. Example:

Dr. James Hough died Sept. 17, 1954, and his wife Mary received $40,000.00 as beneficiary of the doctor from the A.B.C. Life Insurance Co. Mrs. Hough elected to receive for ten years annuity payments of $6,000.00, in this case the expected return would be $60,000.00 (10 × $6,000.00). The taxable portion of the $6,000.00 annual payment would be determined as follows:

Amount received each year		$6,000.00
40,000.00 / 60,000.00 × 6,000.00	$4,000.00	
Wdow's exclusion	1,000.00	5,000.00
Taxable to Mrs. Hough each year		$1,000.00

If Mrs. Hough elected to receive the payment over her life expectancy the expected return would be computed at the annual amount received multiplied by her life expectancy.

Where a taxpayer purchases a life insurance contract and continues the payments, the proceeds received by him on death of the insured are treated as follows:

Dr. Henry Serra purchased a $50,000.00 life insurance contract from the insured for $18,000.00 in 1948, for which he was made a beneficiary. Dr. Serra paid all the premiums from that date to the date of the insured's death on November 13, 1954, which totaled $13,000.00.

Amount paid for policy	$18,000.00
Premiums paid	13,000.00
Total cost of policy	$31,000.00
Amount received	50,000.00
Taxable in 1954, in full	$19,000.00

Surrender of life insurance contract

The difference between the amount received on surrender of a life insurance contract and its cost is taxable in full in the year of surrender where the cost of the policy to date of surrender is more than the amount received; the loss sustained is not allowable as a deduction on the income tax returns (losses sustained on the sale of personal assets are not deductible for income tax purposes). Dividends received from an insurance contract while a policy is in force are not taxable; they are treated as a *reduction in cost of the policy.*

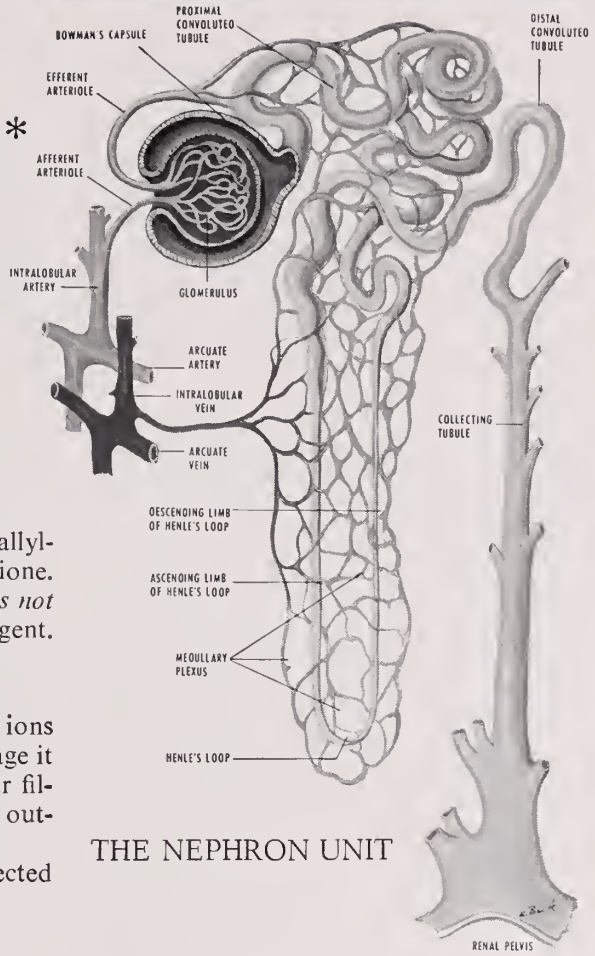
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THE NEPHRON UNIT

STRUCTURE

Mictine, brand of aminometramide, is 1-allyl-3-ethyl-6-aminotetrahydropyrimidinedione. Mictine—result of years of research—*is not* a mercurial, xanthine or sulfonamide agent.

ACTION AND EFFECTIVENESS

Mictine inhibits reabsorption of sodium ions by the renal tubule. In therapeutic dosage it has not caused any effect on glomerular filtration rate, renal plasma flow, cardiac output, heart rate or blood pressure.

Approximately 70 per cent of unselected edematous patients respond to Mictine.

TOLERANCE

Mictine is without serious toxic effects as used. It has not produced any alteration in the blood or blood-forming organs or in renal or hepatic function. At times headache or gastrointestinal symptoms (anorexia or nausea but rarely vomiting or diarrhea) have occurred, however, these effects may be reduced to a minimum by giving Mictine on an interrupted dosage schedule.

ADMINISTRATION

Mictine is useful primarily in the *maintenance* of an edema-free state and in the *initial and continuing* control of patients in mild congestive failure. In such patients, dosage is one to four tablets daily *with meals*, in divided doses on an interrupted schedule. An interrupted dosage schedule may be accomplished by giving the drug on alternate days; or by its administration for three consecutive days and its omission for four consecutive days.

Mictine also may be used for *initial* diuresis in *more severe* congestive states, particularly when mercurial diuretics are contraindicated. In these more severe congestive states, dosage is four to six tablets daily *with meals*, in divided doses on an interrupted schedule similar to those mentioned above.

SUPPLIED

Uncoated tablets of 200 mg. in bottles of 100.

**Trademark of G. D. Searle & Co.*

SEARLE

THE DOCTOR AND HIS INCOME TAX

continued from page 34

Sale of Personal Residence at Gain

Under the old code a taxpayer who sold his personal residence at a gain would not be required to pay tax on the gain if he or she expended the full selling price of the old residence towards the purchase of a new personal residence provided:

(1) A new personal residence was purchased either one year before or one year after the sale of the old residence *or*

(2) began construction of a new personal residence within one year after the sale of the old residence and occupied such newly constructed residence within six months thereafter.

The new code provides the same condition noted above except that a taxpayer would be permitted to deduct any selling and fixing up expenses incurred within ninety days period prior to contract of sale of the old residence as follows:

(1) Dr. John Devoe on January 10, 1954, purchases a personal residence at a cost of $20,000.00. On January 21, 1954, he sold it for $30,000.00, having expended $1,200.00 for paint and repairs prior to selling and paid $800.00 in selling commissions. On December 10, 1954, Dr. Devoe purchased another residence which cost him $26,000.00. Dr. Devoe would pay tax on the following gain:

Selling price of old		$30,000.00
Fixing up	$1,200.00	
Selling commissions	800.00	2,000.00
Net selling price		$28,000.00
Cost		20,000.00
Actual gain		$ 8,000.00
Net selling price		$28,000.00
Cost of new residence		26,000.00
Taxable gain for 1954		$ 2,000.00

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Corner Chalkstone & Academy Aves.

ELMHURST 1-1957

(2) Assume that in (1) above all the facts are the same except that Dr. Devoe paid $28,000.00 for his new residence, he would not be liable to tax on the sale since he had expended the full actual gain in acquiring his new residence.

Accident and Health Benefits of Employees

Although the subject does not directly concern itself with the medical practitioner, he may be called upon to furnish statements to employers on behalf of his patients who are affected. The new code provides the following exclusion from the employee's gross income if he is reimbursed for the following expenses by an employer-financed accident and health plan:

(1) *Medical care payments.* Any reimbursement received from an employer's financed plan for medical expenses incurred by the employee, his spouse or any of his dependents would be excluded from the employee's gross income, whether he paid the expense so incurred in the year he received the reimbursement or not. The exclusion would not apply if the employee deducted the amount so expended as medical expense on his return.

(2) *Payment for permanent injury.* Any payment received from such a plan by an employee for the permanent loss or loss of use of a member or function of the body, or the permanent disfigurement of either the employee, his spouse, or his dependents would be excluded from the employee's gross income in the year of receipt. The period of absence from work because of this injury would have no bearing; such an absence could be for one day, one year or more.

Compensation for loss of wages

Any employee who, because of illness or personal injury, receives payment for loss of wages under an employer's financed plan, would be permitted to exclude from his gross income the first $100.00 of such payment provided:

(1) When the absence is due to *illness*, payment received for the first seven-day period of such absence would be fully taxable unless the employee was hospitalized for one day (overnight) during the period of such absence.

(A) Henry Shivers, an employee of the New Method Corporation was absent from work four weeks, because of such illness; he was not confined to a hospital at any time during the period. His employer's financed plan reimbursed him for the loss of his wages to the ex-

tent of $120.00 a week. Mr. Shivers' payment would be treated as follows:

Period	*Excludable*	*Taxable*
1st week	none	$120.00
2d week	$100.00	20.00
3d week	100.00	20.00
4th week	100.00	20.00
Total	$300.00	$180.00

(B) If in (a) above Mr. Shivers was ordered to a hospital for at least one day during the period of absence then the first $100.00 of the weekly payment received would be excluded from his gross income.

(2) When the absence is due to personal injury (whether on or off the premises), the first $100.00 of any payment received for loss of wages would be excluded whether he was confined to a hospital or not during the period of his absence.

Contributions

Under prior law a taxpayer was not permitted to deduct in excess of 20% of adjusted gross income (line 6 page 3 of Form 1040) with respect to contributions made during the year to charitable, scientific and educational organizations. The new law has made a change in this respect; it now permits a taxpayer to deduct an additional 10% of adjusted gross income for contributions made to

(1) an educational institution which has normally a regular faculty, curriculum, and a regularly organized student body.

(2) a hospital which provides medical care, educational or research facilities.

(3) a church, conventions of or associations of churches.

In addition the taxpayer is also permitted to further deduct a maximum of 20% of adjusted gross income with respect to all contributions to other charitable organizations to which is added the balance remaining after the 10% deductions permitted in (1) (2) (3) above.

Dr. William Jones had adjusted gross income of $12,000.00; during the year he contributed to St. James Episcopal Church, $1,000.00 and also contributed to R. I. Hospital, $500.00. He also donated to the American Red Cross $1,800.00. His contribution deduction would be determined as follows:

Adjusted gross income			$12,000.00
Contributions	*Amount*	*Allowable*	
St. James Church	$1,000.00		
R. I. Hospital	500.00		
Total	$1,500.00	$1,200.00	(10%)
Balance	300.00		
Red Cross	1,800.00	2,100.00	
Total deduction			$3,300.00

A taxpayer who donates stock, securities, or an asset that has appreciated in value will be permitted to use the fair market value of the gift as the basis of his contributions whereas if he sold it he would be required to report and pay tax on the gain even though he gave the proceeds to a charitable organization. Examples:

(1) Dr. James Tappan in 1950, purchased 100 shares of A.B. Motors common stock at a cost of $2000.00. On July 1, 1954, it had a fair market value of $10,000.00. If Dr. Tappan sold the stock on that date and gave the cash to the Red Cross, he would be required to report a long-term capital gain of $8000.00, in his return and pay tax on 50% or $4000.00, and of course would be allowed to enter in his return a charitable contribution of $10,000.00, whereas if Dr. Tappan transferred the stock to the Red Cross he would report no gain and still be treated as having given $10,000.00 to the Red Cross.

(2) Assume in (1) above that the stock cost Dr. Tappan $10,000.00 in 1940, and on July 1, 1954, it had a fair market value of $2,000.00, then it would be more advantageous for the doctor to sell the stock and make the $2,000.00 donation in cash to the Red Cross, he would then be permitted a long-term capital loss of $8,000.00, which could be used in that year against other capital gains, if any, and if not he would be entitled to deduct $1,000.00 against other income and carry the loss of $9,000.00 to the next five succeeding years if necessary.

A taxpayer may give an existing policy on his life to an exempt organization; the basis of the gift will be its value at the time of the gift (cash surrender); he must assign all rights in the policy irrevocably to the charity, and also make it the irrevocable beneficiary. In subsequent years the taxpayer may deduct the premium he pays on the policy as a charitable contribution as follows:

Dr. William Sullivan on Dec. 10, 1954, assigned a $100,000.00 insurance contract on his life to St. Joseph's Hospital. He assigned all rights and interest to the hospital, and in addition he made it the irrevocable beneficiary and also agreed to pay the annual payment of premium of $7,000.00. The policy on the day it was assigned had a value of $10,600. Dr. Sullivan would be treated as having made a charitable contribution of $10,600.00 on his return for 1954. The doctor

continued on next page

would also be permitted in each of the subsequent years to treat the premiums he paid of $7,000.00 as charitable contributions.

Interest Paid

All interest paid on personal transactions are deductible in full on page 3 of the return if the taxpayer uses itemized deductions. A list of deductible and non-deductible interest payments follows:

Deductible

Interest paid on mortgage whether on personal home or professional building.

Interest paid on purchases of equipment on installment basis if identified.

When the interest is not identified on an installment purchase, the new law provides that a taxpayer may add his balance for each month, divide by 12 and multiply the result by 6% as follows:

Dr. Henry Williams on January 10, 1954, purchased equipment for his office at a cost of $3,800.00 which included interest charges for 20 months. He paid $800.00 and $150.00 a month beginning February 10, 1954. The total of the monthly balances for 1954 would be $26,100.00. The interest deduction for 1954 would be computed as follows:

Total monthly balance	$26,100.00
Divided by 12	2,175.00
Interest deduction, 6% of above	130.50

Interest paid by an occupant of cooperative house or apartment project.

A life insurance loan if the interest is paid in cash.

Interest paid on a loan from a corporation of which the borrower is an officer or stockholder providing the loan is a *bona fide* debt.

Several years' interest paid in advance in one year by a cash basis taxpayer.

Non-deductible

Interest paid on loans used to purchase tax-free bonds of governments or State, etc.

Interest paid to a member of a taxpayer's family unless he can prove that it is legitimate loan and there is a legal debtor-creditor relationship between the taxpayer and the member of family.

Interest paid on mortgage on real estate or home of taxpayer's mother, father or relatives, or other individual.

The interest paid by the taxpayer is deemed to be a gift since there is no legal obligation upon him to pay.

Interest paid where there is no legal obligation to pay.

Interest on a loan or insurance policy where the interest is not paid by the insured when due and the company reduces the cash surrender value of the policy by the interest payment due.

Loans of $200.00 and borrower receives $180.00, there is no interest deduction until the $180.00 is paid, the balance of $20.00 will be deductible as interest in the year in which it is paid.

Amounts paid where there is no debt with respect to the person paying such so-called interest.

Where a taxpayer has borrowed money from a bank and gives a note for the interest when due.

Interest on loans used to purchase tax-free obligations.

Taxes

Under the old law, taxes paid were deductible in the year in which they were paid by the person on whose property they became lien. There has been no change in this respect except in those cases in which the taxpayer sells the property, then both the seller and the purchaser may deduct the tax paid proportionately as follows:

(1) the seller may deduct that portion of the tax allocated to date of sale, *and*

(2) the buyer may deduct that portion of the tax allocated from date of purchase to the end of the taxable year as follows:

(1) Dr. Henry Billard sold his personal residence to Dr. William Burdick on July 1, 1954. On January 9, Dr. Billard paid the full year's tax of $820.60 (January 1 to December 31). Dr. Burdick paid to the seller $410.30 as his portion of tax to June 30. Dr. Billard will be permitted a tax deduction of $410.30 if he itemizes his deductions and Dr. Burdick may take a deduction of $410.30. Under prior law only Dr. Billard could have deducted the full tax paid of $820.60 and Dr. Burdick would have treated the $410.30 as additional cost of the property.

A few examples of personal taxes paid which are either deductible or not deductible on Page 3 of Form 1040:

Deductible

Taxes for which taxpayer is personally liable.

Taxes paid on cooperative apartment.

Husband paying tax on property owned solely by wife if joint return is filed.

Taxes paid by tenant, but landlord must include amount of tax as rental income.

Back taxes by person upon whom they became a lien, when paid.

Personal residence.

Summer residence.

R. I. Cash Sickness (1%).

R. I. Sales tax (2%). May be estimated if reasonable.

continued on page 40



ELECTRON PHOTOMICROGRAPH

Klebsiella pneumoniae 39,000 X

Klebsiella pneumoniae (Friedländer's bacillus) is a Gram-negative, capsulated organism commonly involved in various pathologic conditions of the nose and accessory sinuses, in addition to bronchopneumonia and bronchiectasis.

It is another of the more than 30 organisms susceptible to

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100 mg. and 250 mg. capsules

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THE DOCTOR AND HIS INCOME TAX

continued from page 38

R. I. gasoline tax (4% gal.) may be estimated if reasonable.

Registration of automobile.

License to drive automobile.

Not deductible

Son paying taxes on property owned by parent (gift).

Assessments for local benefits (street, sidewalk or curb paving).

Husband paying tax on property solely owned by wife if separate returns are filed.

Stockholder who pays tax for corporation. Amount may be treated as additional investment or loans.

Federal jewelry tax.

Federal cosmetic tax.

Federal admission tax.

R. I. liquor tax.

Federal luggage tax.

Federal fur tax.

Federal income tax.

R. I. cigarette tax.

Employees' railroad retirement tax.

Fishing, hunting, dog licenses.

Insurance premiums paid under compulsory automobile insurance laws of a state.

Medical Expense

Under the old code a taxpayer under 65 years of age was limited in his medical expense deduction to the excess of 5% of adjusted gross income. The 5% limitation did not apply with respect to those taxpayers who have attained age 65 or more during the taxable year.

The new code has made two changes with respect to the medical deduction in that the 5% limitation has been reduced to 3% for those taxpayers under 65; it also provides that all taxpayers regardless of age must reduce expenditures for medicines, drugs, prescriptions, etc., by 1% of adjusted gross income, as follows:

Mr. William Bowers, age 63, during 1954 had adjusted gross income of $8,000.00. During the year he expended $175.00 for drugs, medicines and prescriptions, $200.00 for doctors' services and $400.00 for hospital services.

Adjusted gross income		$8,000.00
Medicine and drugs	$175.00	
1% of adjusted gross	80.00	
Balance	$ 95.00	
Doctors' services	200.00	
Hospital services	400.00	
Total	$695.00	
3% of adjusted gross ($8000.00)	240.00	
Medical expense deduction	$455.00	

If Mr. Bowers was 65 years of age in 1954, he would be entitled to the full $695.00 as a medical expense deduction since the 3% limitation would not apply.

The new code has also increased the maximum medical expense allowable as deduction in any year from $1,250.00 (old code) to $2,500.00 for each exemption on the return not including the added exemption allowable to those taxpayers who are blind or 65 years of age or more as follows:

Status	*No. of exemptions on return*	*Maximum allowable*
Single	2	$ 5,000.00
Married (separate return)	2	5,000.00
Married (joint return)	4	10,000.00
Head of household	4	10,000.00
Surviving spouse	4	10,000.00

The new law has corrected an inequity to those taxpayers who incurred medical expense, died during the year, and had not paid the expense up to date of death. Under the old law the expense so paid by the estate of the decedent was not deductible but under the new code it is, provided that if the estate pays the decedent's medical expense within one year after his death, the amount so paid will be treated as having been paid by the decedent and deductible if it qualifies on the last return filed for him as follows:

continued on page 42



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- GASTROPTOSIS
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- VISCEROPTOSIS
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- ORTHOPEDIC

***John S. Maciel*, Pharmacist**

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REFERENCE: 1. Kirwin, T. J., Lowsley, O. S., and Menning, J.: Am. J. Surg. 62:330-335, December, 1943.

THE DOCTOR AND HIS INCOME TAX

continued from page 40

In 1954, Mr. William Doe incurred a medical bill of $600.00, which he did not pay up to date of his death June 1, 1954. It was paid by his executor on Nov. 10, 1954. The executor may deduct the medical expense deduction on Mr. Doe's individual return for 1954. The deduction applies only with respect to Mr. Doe's unpaid medical, any bills incurred by his dependents would not be allowed.

Medical expenses are deductible in the year paid and not in the year incurred, therefore if an individual's present wife incurred a medical bill when she was single the husband would be permitted to deduct the bill in the years paid, because she was his wife when paid. The same will hold true with respect to a son who was a dependent in 1951 when the bill was incurred but is not a dependent in 1954, when the parent pays the bill. If the son was not a dependent when the bill was incurred and is a dependent in the year it is paid the parent or person who furnished over one-half his support would be permitted the medical expense deduction.

An individual may be a dependent for medical expense purposes and not for exemption purposes as follows:

Dr. William Beane during 1954 paid medical and hospital bills of $2.300.00 for his mother who did not live with him, and during 1954 Dr. Beane's mother had income from dividends of $2,000.00. Although Dr. Beane may not claim a dependency deduction of $600.00 for his mother as she had $600.00 or more of gross income during the year, he would be allowed to deduct the medical expense he paid of $2,300.00, if it qualified, for his mother since he furnished over one-half her support during the year.

Recoveries of medical expense in current years which was deducted during prior years is treated as follows:

Taxpayer	*Medical expense taken previous year*	*Received in 1954*	*Taxable in 1954*
A	200	$100.00	$100.00
B	100	100.00	100.00
C	20	250.00	20.00

Where a taxpayer used standard deduction in previous year, any reimbursement for medical expense he receives in current year would not be taxed.

Dividend received exclusion

The new code has provided an entirely new concept in the field of federal taxation in that each

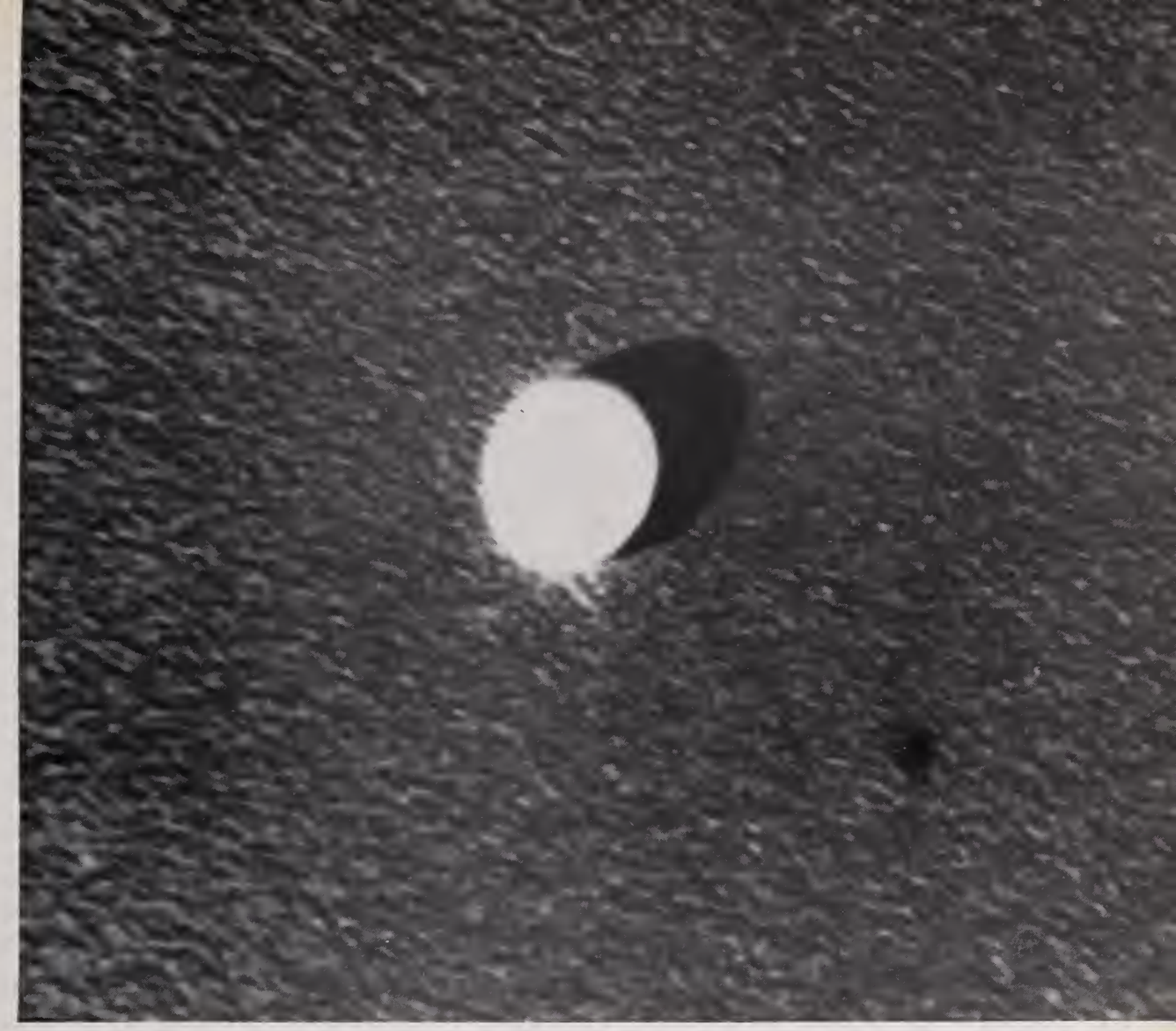
continued on page 50



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Hillside Farms
PHENIX AVE. OAKLAWN, R.I.



ELECTRON PHOTOMICROGRAPH

Staphylococcus aureus 44,000 X

Staphylococcus aureus (Micrococcus pyogenes var. aureus) is a Gram-positive organism commonly involved in a great variety of pathologic conditions, including

pyoderma • abscesses • empyema • otitis • sinusitis • septicemia bronchopneumonia • bronchiectasis • tracheobronchitis • and food poisoning.

It is another of the more than 30 organisms susceptible to

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DISTRICT MEDICAL SOCIETY MEETINGS

KENT COUNTY MEDICAL SOCIETY

At the annual meeting of the Kent County Medical Society held on December 8, 1954, the following officers were elected to serve for 1955:

President: Briand N. Beaudin, M.D.
Vice President: Peter C. Koch, Jr., M.D.
Secretary: Paul G. Haltenberger, M.D.
Treasurer: John A. Mack, M.D.
Delegates: Peter C. Erinakes, M.D., Edmund J. Hackman, M.D., Russell P. Hager, M.D.
Councillor: Arthur E. Hardy, M.D.
Alternate Councillor: Joseph C. Kent, M.D.

NEWPORT COUNTY MEDICAL SOCIETY

The last meeting of the Newport County Medical Society was called to order by Dr. Robert Bestoso, President, at 7:30 P.M. on December 1, 1954, at the Hotel Viking with twenty-five members attending.

The speaker of the evening was Mr. John Howard Benson, nationally known sculptor and authority on calligraphy. He gave the society a most erudite and instructive conference on the origin of the Old Stone Mill in Newport, accompanied by a series of slides explaining the various architectural and engineering features that entered into the construction of the mill.

The minutes of the last meeting on September 22d were read and approved.

COMMUNICATIONS: A letter from Capt. Enyart, Commanding Officer at the Naval Hospital, was read, expressing his appreciation for the collaboration of the physicians in the County during the *Bennington* disaster.

A letter was read also from the Newport Hospital Student Nurses, announcing their forthcoming Christmas formal dance. All doctors were urged to attend.

COMMITTEE REPORTS: Dr. Brownell, delegate to the State Society, reported on the Conclusions of that Society at their last meeting:

1) That all dues would be rated at $50.00 per annum.
2) That the problem of liability insurance obtained through the State Medical Society is approaching a solution.
3) That all doctors answer questionnaires sent out by the 1st Naval Headquarters regarding their attitude in the matter of civilian doctors being contracted to work on the Naval Base rendering service to civilian employees.

Dr. Zamil reported on the Diabetes Detection Drive, urging all members to fill out the cards, indicating the number of urines checked, and the cases of diabetes discovered. He mentioned that the first Diabetic Fair was a complete success, and requested that all positive patients be re-evaluated as positive diabetes and reported to the local committee for their completed survey report.

NEW BUSINESS: Dr. Adelson made a motion that the secretary of the society address a letter to the Representative Council expressing the society's displeasure concerning the popular statement that "It's easy to get a medical statement from any doctor in Newport." This motion was seconded and passed by the members of the society.

A second motion was made by Dr. Adelson that a letter be sent to Dr. Jerech expressing the regrets of the various members of the society concerning her impending departure. This was seconded by Dr. Ceppi and passed.

The meeting adjourned at 10:00 P.M.

Respectfully submitted,
JOSE M. RAMOS, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, November 1, 1954. The meeting was called to order by the president, Dr. William J. O'Connell, at 8:30 P.M.

Minutes of Previous Meeting

The reading of the minutes of the previous meeting was omitted with the approval of the membership present in view of the fact that the complete minutes are to be published in the RHODE ISLAND MEDICAL JOURNAL.

Report of the Secretary

Dr. Michael DiMaio, secretary, reported that all members of the association had been cordially invited to attend the John F. Kenney Clinic Day

meeting at the Pawtucket Memorial Hospital on Wednesday, November 3, 1954.

Award of Membership Certificates

The president awarded certificates of membership to the physicians elected at the October meeting of the association.

Presentation of Arnar-Stone Laboratories Representative

Mr. L. C. Phinney, of the Arnar-Stone Laboratories, Inc. of Evanston, Illinois, who had a technical exhibit at the meeting, was introduced by Dr. O'Connell to the membership. Mr. Phinney spoke briefly regarding the pharmaceuticals available through his company.

Scientific Program

The president introduced as the speaker of the evening Dr. Wyland F. Leadbetter, chief of Urology at the Massachusetts General Hospital in Boston, Massachusetts, who spoke on the subject of "Office Urology."

Dr. Leadbetter presented in a very enlightening manner many of the urological problems that are encountered in office practice. Tortion of the testicles, he stated, is always to be considered a real emergency. However, this condition is rarely seen early enough to save the involved testicle. The sudden onset of pain in the testicle and prostration are the usual complaints and he recommended operation as soon as possible. Dr. Leadbetter feels that occasionally bilateral operation is indicated in order to prevent the same condition in the opposite testicle.

One of the important congenital defects encountered is hypospadia. He recommends early correction (before school age) and the results are usually satisfactory. Another defect which he mentioned is undescended testicle. This condition may be associated with an inguinal hernia and a fairly good percentage of these patients develop tumors of the testicle later in life. The treatment of this condition varies considerably because of the conflicting literature. He indicated that if there is bilateral undescended testicle, the pituitary gonadotropin may be worthwhile treatment. Where there is one normal and one undescended testicle, Dr. Leadbetter seems to think that early operation brings about the best results. This latter condition is not the result of hormonal deficiency.

The several scrotal lesions that he mentioned are varicocele, hydrocele, spermatocele, and epididymitis. A varicocele is easily identified. A hydrocele on the other hand may be less readily diagnosed, although transillumination aids in the diagnosis. Oftentimes this condition needs to be investigated to rule out an underlying tumor. Epididymitis may be acute or chronic or tuberculous in nature. In tuberculosis, there is an occasional draining sinus.

continued on next page

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Urethral inflammatory conditions are gonorrheal urethritis and pyogenic urethritis. Culture and smear, as well as a good history help in the diagnosis. The speaker's observations confirm our own in that there are considerably fewer cases seen at the present time than prior to the advent of the sulfonamides and antibiotics. Staphylococcal infections are the most common cause of nonspecific urethritis and, usually, this is secondary to an infection of the prostate or seminal vessels. Viral urethritis is another problem in which a purulent urethral discharge is noted but the smear is negative. This condition may be associated with Reiters Syndrome. Treatment of viral urethritis is not completely satisfactory. Neoarsphenimine is used and so are some of the broad spectrum antibiotics. Prostatitis and urethritis are usually associated with some urinary pain and urethral discharge in the morning. Prostatic massage and an examination of the secretions are helpful in the diagnosis. The antibiotics are not helpful in these conditions unless the prostate drains freely. The purpose of prostatic massage is to provide drainage and to unblock blocked ducts. Dr. Leadbetter recommends using antibiotics and massage one time per week in these conditions, until the prostate gland feels reasonably normal and is draining normally. Proper drainage eliminates the clumping of the pus cells when the discharge is examined microscopically. The speaker indicated that prostatitis may come from a secondary focus such as teeth, tonsils, etc.

It was the speaker's feeling that a child with any kind of urinary trouble should have an intravenous pyelogram. This also applies to anyone having hematuria. A complete urological workup is often necessary to rule out multiple lesions of the genitourinary tract. In speaking about carcinoma of the prostate, Dr. Leadbetter pointed out that many patients over fifty years of age that have a prostate which does not feel right should be seen by a urologist. Twenty per cent of males over fifty years of age will develop carcinoma of the prostate. In this condition, over fifty per cent of the patients have a five-year survival, thirty per cent a ten-year survival.

Dr. Leadbetter's talk was well received.

The meeting adjourned at 9:30 P.M.

Attendance was 87.

Collation was served.

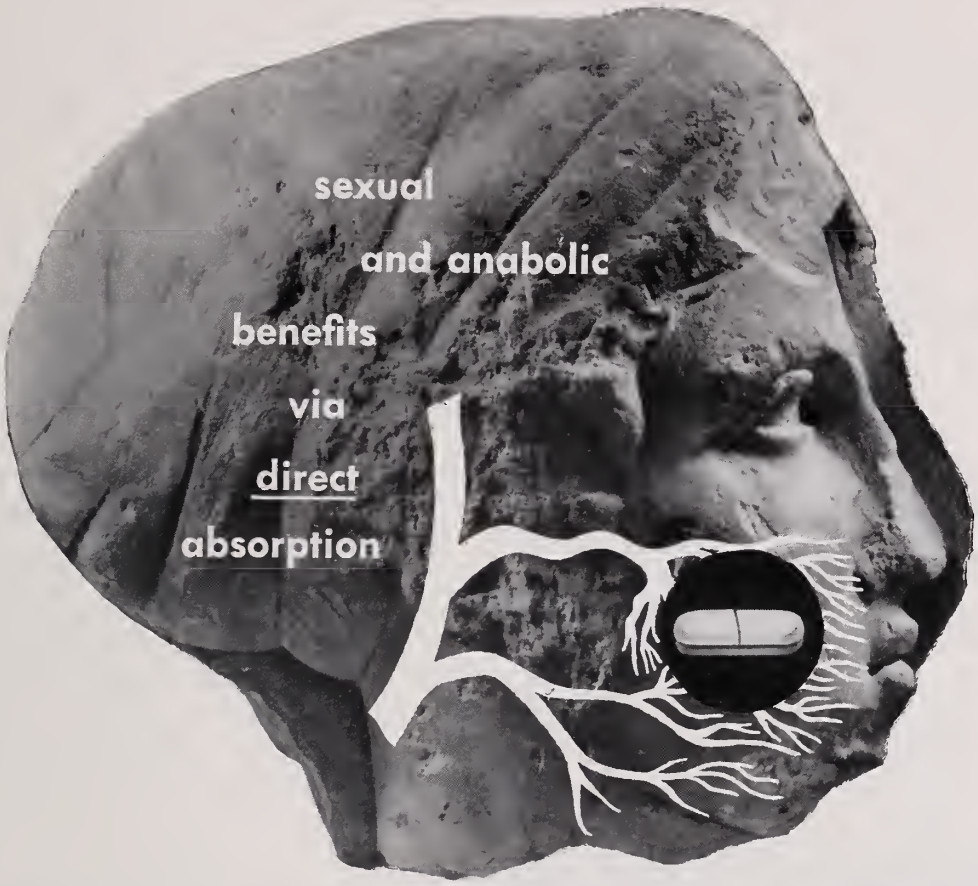
Respectfully submitted.

MICHAEL DIMAIO, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, December 6, 1954. The meeting was

continued on page 48



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C I B A Summit, N. J.

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PROVIDENCE MEDICAL ASSOCIATION

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called to order by the president, Dr. William J. O'Connell, at 8:30 P.M. Due to inclement weather the attendance at the meeting was far less than usual.

Minutes of Previous Meeting

The minutes of the previous meeting were approved and were not read since it was announced that they would be published in the RHODE ISLAND MEDICAL JOURNAL.

Report of Executive Committee

The secretary, Dr. Michael DiMaio, reported that the Executive Committee had taken the following actions:

1. In accordance with the By-Laws it prepared and submitted by mail to the membership a slate of officers to serve in 1955, and to be voted upon at the annual meeting on January 3, 1955. Counter nominations to this slate must be in writing, signed by ten members of the association, and submitted to the secretary at least ten days prior to the annual meeting.

2. The committee authorized the president to appoint a By-Laws Review Committee to meet with the legal counsel of the Rhode Island Medical Society to study and review the matter of membership requirements of the association, and to submit a report to the Executive Committee on its findings at a subsequent date.

3. The committee voted that a citation be prepared in proper form for presentation to the city's two rescue squads at the annual meeting on January 3, 1955.

It was moved that the report be approved and placed on file. The motion was seconded and adopted.

Announcement by the President

The president announced that the committee consisting of Drs. James H. Fagan and Angelo Archetto had submitted the association's tribute to the late Dr. Frank E. McEvoy.

Election of New Members

The secretary reported that the Executive Committee recommends for election to active membership the following physicians: Ivan Basilevich, M.D., State Hospital for Mental Diseases, Howard, Rhode Island, and Charles Joseph Hutchinson, M.D., Andrews House, Brown University, Providence, Rhode Island.

It was moved that both nominees be elected as active members of the association. The motion was seconded and adopted.

Scientific Program

The president introduced Dr. Magnus I. Smedal, Chief of Radiological Service at the Lahey Clinic and the New England Baptist Hospital, and Research Associate at the Massachusetts Institute of Technology, who spoke on "Observations on Supervoltage X-Ray Therapy and Cathode Ray Therapy."

Dr. Smedal reviewed the use of high voltage X ray in the treatment of medical problems. He presented this very difficult subject in a very pleasing and understandable manner.

In selected ambulatory patients, the Massachusetts Institute of Technology's three million volt x-ray machine is used. The speaker presented all the advantages and disadvantages of x-ray radiation therapy. He was particularly emphatic about the advantages of rotational x-ray therapy. His excellent lecture was supplemented by the use of lantern slides.

An interesting discussion period followed the presentation.

The meeting adjourned at 10:05 P.M.

Attendance was 39.

Collation was served.

Respectfully submitted,

MICHAEL DIMAIO, M.D., *Secretary*



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WOONSOCKET DISTRICT SOCIETY

A meeting held in the Woonsocket Hospital auditorium was called to order by President Joseph McKenna at 8:50 P.M., on December 14, 1954. Dr. Alton Thomas was appointed acting secretary. The minutes of the last meeting were read and approved.

The application of Ernest L. Dupre, M.D. for membership in the Woonsocket District Society was read and is to be processed acording to the society's by-laws.

Messages of appreciation for flowers sent by the society were read from Dr. Edgar Tanguay, who recently lost his wife, and from Mrs. Sylvio Remy. Dr. Remy died in October, 1954.

Dr. McKenna informed the society that Commissioner of Public Safety for the city of Woonsocket, Gustave LaBreche, had requested assistance from the society in selecting the proper equipment for the emergency bag carried by the police ambulance and by the Woonsocket Fire Department rescue vehicle. On a motion made by Dr. Francis King and seconded by Dr. Morrison, the president appointed a committee of two to act as advisers on this matter. (Dr. Gerald Lamoureux, chairman, and Dr. Harry Levine.)

A nominating committee for officers for the coming year was appointed by the president and consisted of Drs. Francis King, Joseph Bliss and Carlo DeStefani. They returned the following slate:

President—Dr. Saul A. Wittes
Vice President—Dr. Francis Vose
Secretary—Dr. Alton Thomas
Treasurer—Dr. Paul Boucher
Censors—Drs. Joseph Reilly, Francis King and Victor Monti
Councillor—Dr. Joseph McKenna
Delegates—Drs. Francis Vose and Alfred King.

Dr. Francis Vose nominated from the floor Dr. Joseph Bliss for the office of Vice President. Seconded by Dr. Leo Dugas. A written ballot was taken and Dr. Vose was elected vice president. As no other counter nominations were proposed, the president instructed the secretary to cast one vote for the above slate of officers, and they were duly elected.

Dr. McKenna turned over the gavel to the new president, Dr. Saul Wittes, at 9:30 P.M. As there was no further business, the meeting was adjourned at 9:32 P.M.

Attendance was 20 members.

No refreshments were served.

Respectfully submitted,
ALTON P. THOMAS, M.D., *Secretary*

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THE DOCTOR AND HIS INCOME TAX

continued from page 42

taxpayer may exclude the first $50.00 of taxable dividends received in 1954 from domestic corporations. The exclusion applies to all taxpayers whose taxable year ends after July 31, 1954.

Where a husband and wife file a joint return, the $50.00 exclusion is permitted to both provided that each spouse has divided income of $50.00 or more in their own right. If only one spouse had dividend income then the $50.00 exclusion would apply only to the spouse who received the dividends irrespective of whether separate or joint return is filed. Examples:

(1) Dr. Henry Scholl during 1954 received taxable dividends from domestic corporations in the amount of $760.00, and his wife May received $250.00 on securities owned by her. Dr. Scholl would report $710.00 (760.00 − 50.00) and Mrs. Scholl $200.00 (250.00 − 50.00) on their respective returns if they filed separately and $910.00 if they filed jointly.

(2) Assume in (1) above that Dr. Scholl owned all the securities. Dr. Scholl would only be allowed an exclusion of $50.00 and report in his return $960.00 ($1,010.00 less $50.00) whether he filed separately or jointly.

Dividend received credit

In addition to the exclusion of the first $50.00 of dividends each taxpayer is permitted a 4% tax credit on all dividends received *after July 31, 1954.*

The credit applies to all taxable dividends included in gross income which is not a further exclusion but a cash credit against the tax due on the return. The credit cannot in any case exceed the tax due as the law specifically provides no refund if tax due is less than credit.

The credit is limited the lesser of (a) 4% of the dividends received after July 31, 1954, (b) Tax shown on return or (c) 2% of taxable income (line 5 page 3).

(1) Dr. Mark Abbott during 1954 received $8,000.00 as dividends from the Acme Corporation, $2,000.00 each on Jan. 15, April 15, July 15, and Oct. 15 respectively. Dr. Abbott had taxable income of $6,000.00. He was married, had no dependent, filed a joint return and his tax for the year was $760.00. On his return he reported dividends of $7,950.00 (8,000.00 − 50.00 exclusion) and his credit would be $80.00 the lesser of the following:

4% of dividends of $2,000.00 after July 31, 1954	$ 80.00
tax due on return	760.00
2% of taxable income of $6,000.00	120.00

(2) Assume in the above example that the dividends were paid semi-annually in the amount of $4,000.00 on Feb. 15 and $4,000.00 on Aug. 15, 1954, the allowable dividend credit would be $120.00, the lesser of the following:

4% of $4,000.00 received after July 31, 1954	$160.00
tax due on return before credit	760.00
2% of taxable income of $6,000.00	120.00

The credit would be computed in the same manner whether a joint or a separate return was filed by Dr. Abbott and Mrs. Abbott.

Retirement income credit

This is an entirely new concept regarding credits against tax and for many individuals will result in a tax saving for 1954. In order to qualify, a taxpayer must have earned income of $600.00 or more for any ten years preceding the taxable year. It is necessary to determine the retirement income which may not in any case exceed $1200.00 for each taxpayer which is applicable to both husband and wife if a joint return is filed. The credit against tax may not be in excess of $240.00 (20% of $1200.00), and in no case may it exceed the tax due before the credit is applied.

Retirement income includes for those taxpayers who

(1) *Have attained age 65 before the close of the taxable year:* Pensions, annuities, dividends, interest and gross rental income.

(2) *Have not attained age 65 before the close of the taxable year:* Pensions and annuities from a public retirement system such as pensions and annuities received from United States (military excepted), states, cities, towns, District of Columbia, or territories and possessions of U. S.

The retirement income so computed (not in excess of $1200.00) must be reduced by the receipt of any of the following whether the taxpayer is over 65 or not:

(1) Social security pensions

(2) Railroad retirement pensions

(3) Any income earned during the year in excess of $900.00. If the taxpayer is seventy-five years or more by the close of the year, no reduction is necessary where there is earned income in excess of $900.00.

Earned income is construed as wages, salaries, commissions, profits of professional practitioners; the net profit from business where income is derived by investment of capital and services is multiplied by 30% to determine the earned income.

Examples:

(1) Dr. William Heath, age 65, during 1954 had taxable dividend income of $8,000.00 and gross rents of $9,000.00 (net profit of $3,100.00). During his years of practice, Dr. Heath was employed as a visiting physician (employee) by the A.B.C. Corporation, for which he received a Social Security pension of $385.00. He earned as consultant $1,300.00 during the year. Dr. Heath would compute his retirement credit as follows:

Retirement Income		
Dividends	$8,000.00	
Interest	3,000.00	
Gross rents	9,000.00	
Total		$20,000.00
Maximum applicable		1,200.00
Less:		
S. S. Pension	$385.00	
Consultant fees $1,300 less $900.00	400.00	
Total		785.00
Subject to credit of 20%		$415.00
Credit allowable against tax		83.00

(2) Assume in (1) above the facts were the same except that Dr. Heath was 75 years of age in 1954.

Maximum retirement income	$1,200.00
Less Social Security Pension	385.00
Subject to credit of 20%	$815.00
Credit allowable against tax	$163.00

(3) Assume in (2) above that Dr. Heath's tax due for 1954 was (before application of credit) $143.00. He would pay no tax but would not be entitled to a refund of $20.00 as there is no refund where the credit exceeds the tax due for the year.

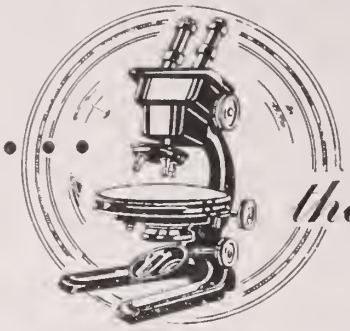
A surviving spouse who had no earned income of $600.00 or more for any of the ten years preceding the current year would qualify if her decedent spouse would have qualified if he or she had lived. Thus—

Mrs. Mary Johnson, widow of Dr. Henry Johnson, did not have earned income of $600.00 or more during any of the preceding ten years. If Dr. Johnson had lived in 1954, he would have qualified and because of this Mrs. Johnson would qualify for the tax credit, if any, because she is the survivor of the taxpayer who would have qualified if he had lived. Of course if Dr. Johnson had lived he would be entitled to the credit, if any, but Mrs. Johnson would not qualify for the credit.

To be continued in the February issue.

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THROUGH . . .  the Microscope

Physicians Slated for Military Service

To meet the Defense Department call for 1,275 physicians for induction next March, draft boards have started processing men through the age thirty-seven. Selective Service headquarters instructed boards to call up for examination those priority III physicians born on or after January 1, 1917, where previously the cutoff birth date was August 30, 1922. Priority I of all ages and Priority II men without restriction as to months of service also are being used for the March call. A total of 300 interns have been selected by the Defense Department for deferment for one year residencies in fifteen medical specialties essential to the military departments. The names were drawn by lot from among more than 1,300 non-veteran interns who asked for further deferment.

Polio in Rhode Island in 1954

The National Foundation for Infantile Paralysis has reported that the polio attack rate in Rhode Island in the year just ended was about 37 per cent lower than the national average, according to provisional reports. Nationwide, the number of cases reported in 1954 was the third highest on record.

Yet in 1953, when 295 polio cases were reported, the attack rate in Rhode Island was 59 per cent higher than the national average. It is impossible to predict where and when polio epidemics will strike, which underlines the need for more effective control measures.

Evaluation of the Salk vaccine, administered to 440,000 U. S. children, in the largest medical experiment of its kind ever conducted, is now in progress. Announcement of the vaccine's effectiveness will be made in the spring of 1955.

During the field trials last spring about 3,500 children in the state of Rhode Island were inoculated with the Salk vaccine.

Federal Government Medical Services

The 80 medical schools in the United States will operate on a budget of approximately $93,408,312 during the fiscal year 1954-1955.

To operate the federal government medical, health, and related activities during the fiscal year 1954-1955, approximately 25 times as much money is required, or approximately $2,141,681,661. This represents one-sixth of the total United States health bill (12 billion dollars), as estimated by the Department of Commerce.

Some 25 federal agencies and departments are involved in this federal government medical program. The Panama Canal Zone with a "fee for service based on the individual's income bracket," represents one type of program, while the State Department's interest in the World Health Organization's health program in some 69 foreign countries is still another type.

The several thousand physicians involved in this federal government medical program include a limited number of "drafted physicians" in the Armed Forces, as well as many volunteers and career men in each of the 25 federal agencies and departments.

Size and cost are criteria for measurement in many instances but a federal government medical service needs to be evaluated as to "policy and ideology"—only well-informed citizens can make such evaluation in a democratic form of government.

The Press Comments on VA Medical Care

The following excerpts from editorial comments on the AMA policy or the VA problem itself are evidence that this question is being considered outside the medical profession itself:

The Indianapolis News, August 21, 1954:

> A welfare-state philosophy which holds that the government, and not the individual, should pay for medical care has established firm roots at U.S. Veterans Administration hospitals here and throughout the country.
>
> These hospitals give free medical care for non-service-connected ailments in spite of the fact that the patients may be wealthy and well able to pay. All the patient has to do is sign a pauper's oath and there is little or no further investigation.

continued on page 54

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1. Riseman, J. E. F. and Brown, M. G. Arch. Int. Med. 60: 100, 1937
2. Brown, M. G. and Riseman, J. E. F. JAMA 109: 256, 1937.
3. Riseman, J. E. F. N. E. J. Med. 229: 670, 1943.

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THROUGH THE MICROSCOPE

continued from page 52

Uncle Sam—and that means the taxpayers—foots the bill. . . .

There is no quarrel with free medical care for veterans whose ailments or disabilities arose from service to their country. . . . But there certainly is a quarrel with a system which gives free handouts to a man who is able to pay just because at one time in his life he served in uniform. . . .

The Boston Herald, September 3, 1954.

Veterans are no longer a special minority class of men who made an extraordinary sacrifice. They are the majority, of the younger generation, at least, who were drafted and served like almost everyone else.

Those who were hurt in battle—or even hurt far from battle—deserve special medical care. But to provide lifetime free care for all veterans is ridiculous.

. . . The AMA deserves attention on this unpopular but important issue.

The Dallas Morning News, September 3, 1954.

The AMA thinks it (tax-supported medical care) should be restricted to those veterans whose disabilities were suffered during their service.

The AMA, it seems to *The News,* is more realistic on the issue (than its opponents). The taxpayer can't extend free medical and hospital care to every veteran's complaint, even to pulling out teeth that rotted eight or nine years after the war ended.

The Des Moines Register, September 2, 1954.

The Register believes that the position of the medical groups is sound; that it is in the interest of the nation on the whole, including veterans, to limit the admission of service-connected cases to veterans hospitals. But even if we disagreed with the medical groups on this question, we would still think they should take a stand on an issue of this kind which involves medical problems. We doubt that any good will is sacrificed by advocating what you believe in. We think it's a good way to gain respect, even from those who disagree with you.

New Orleans States, September 7, 1954.

There is evidence that a considerable section of public opinion backs the medical association position that the veteran able to pay should not get treatment at the taxpayer's expense for his illness and disabilities that are in no way connected with his military service. To us that seems a very reasonable proposition. The (veterans' organization) would be well advised, we think, to endorse this policy. It might result later in better care of the veterans really in need and in the care of their needy dependents. After a while there may not be enough tax money to keep up unlimited treatment for all veterans.

The Danville (Ill.) Commercial-News, September 7, 1954.

Certainly, every veteran with service-connected illness or injury should receive the best medical care available without expense to himself. This is the least the nation can do for him, and Americans never have tried to shirk this obligation; but unless the rapidly growing program of the Veterans Administration is checked, the American people will be obliged to substitute socialized medicine for their present medical system.

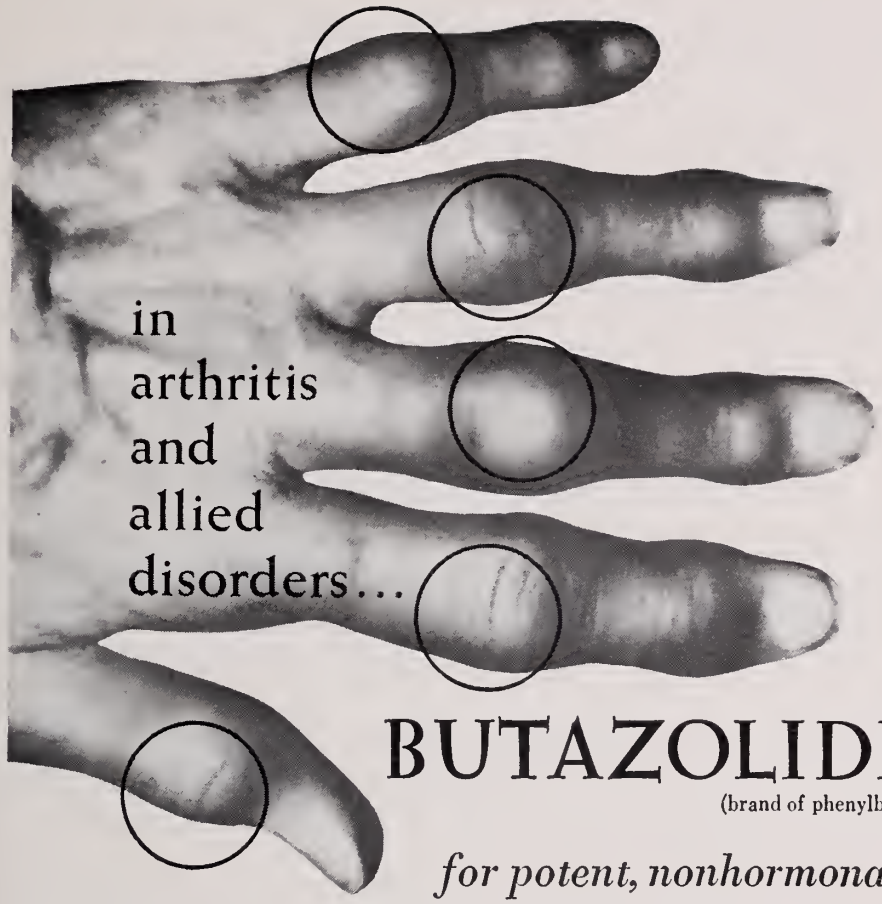
Your AMA Directory Information Card

The new, 19th Edition of the AMERICAN MEDICAL DIRECTORY is now in galley form, and it is expected that the book will be ready for delivery about the middle of 1955. The previous edition was issued in 1950. Since that time, it has not been possible to publish a new edition because changes in the membership structure of the American Medical Association made it difficult to obtain an accurate list of members.

Within the next few weeks, a directory information card will have been mailed to every physician in the United States, its dependencies, and Canada, requesting information to be used in compiling the new directory. Physicians receiving an information card should fill it out and return it promptly regardless of whether any change has occurred in any of the points on which information is requested. It is urged that physicians also fill out the right half of the card, which section requests information to be used exclusively for statistical purposes. Even if a physician has sent in similar information recently, he should mail the card promptly to the Directory Department of the American Medical Association to insure an accurate listing of his name and address. There is no charge for publishing the data, nor are physicians obligated in any way.

The directory is one of the most important contributions of the American Medical Association to the work of the medical profession in the United States. In it, as in no other published directory, one may find dependable data concerning physicians, hospitals, medical organizations, and activities. It provides full information on medical schools, specialization in the fields of medical practice, memberships in special medical societies, tabulation of medical journals and libraries, and statistics on the distribution of physicians and hospitals in the United States.

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*MacKnight, J. C.; Irby, R., and Toone, E. C., Jr.: Geriatrics 9:111 (Mar.) 1954.

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PROGRAM FOR THE SECTIONAL MEETING

of the

AMERICAN COLLEGE OF SURGEONS

Sheraton-Biltmore Hotel, Providence, Rhode Island

March 3, 4, 5, 1955

All Members of the Rhode Island Medical Society are invited to attend the Meeting

Registration Fee $5.00, except for members of the College, residents and interns

THURSDAY, MARCH 3

8:00 a.m. REGISTRATION

8:30-12:00 noon SCIENTIFIC SESSIONS

8:30-10:30 a.m. Henri E. Gauthier, M.D., F.A.C.S., *Chairman, Committee on Arrangements,* Presiding

NEPHRECTOMY (Medical Motion Picture) . . Robert M. Janes, M.D., F.A.C.S., *Toronto*

THE ACUTE GALL BLADDER . . . . . Orland F. Smith, M.D., F.A.C.S., *Providence*

GUIDING THE DAILY CARE OF THE SICK SURGICAL PATIENT
Francis D. Moore, M.D., F.A.C.S., *Boston*

THE CLINICAL ROLE OF PLASMA VOLUME EXPANDERS
Jonathan E. Rhoads, M.D., F.A.C.S., *Philadelphia*

10:30-12:00 noon ***Symposium on Trauma,*** Robert T. Henry, M.D., F.A.C.S., *Pawtucket,* Presiding

EMERGENCY TREATMENT OF ARTERIAL INJURIES
Richard Warren, M.D., F.A.C.S., *Brookline*

OPEN WOUNDS OF THE HAND . . . . . J. Edward Flynn, M.D., F.A.C.S., *Boston*

PHYSIOLOGICAL BASIS FOR THE TREATMENT OF THORACIC TRAUMA
John W. Strieder, M.D., F.A.C.S., *Brookline*

12:00-1:30 p.m. ***Luncheon*** and Program for surgeons interested in the Surgery of Trauma

1:30 p.m. THORACO-ABDOMINAL ECTOPIA CORDIS (Medical Motion Picture)
Hugh B. Lynn, M.D., *Louisville*

2:00-5:00 p.m. Lloyd Brown, M.D., F.A.C.S., *Bangor, Maine,* Presiding

2:00-3:25 p.m. ***Symposium on Pediatric Surgery***

THE MANAGEMENT OF ABDOMINAL TUMORS IN CHILDREN
C. Everett Koop, M.D., F.A.C.S., *Philadelphia*

THE DIAGNOSIS AND MANAGEMENT OF INTESTINAL OBSTRUCTION IN INFANTS AND CHILDREN . . . . . Orvar Swenson, M.D., F.A.C.S., *Boston*

CONGENITAL ATRESIA OF THE ESOPHAGUS WITH TRACHEO-ESOPHAGEAL FISTULA . . . . . Jose M. Ferrer, Jr., M.D., F.A.C.S., *New York*

3:35-5:00 p.m. ***Panel Discussion — Acute Renal Failure***

Moderator: Francis D. Moore, M.D., F.A.C.S., *Boston*

Collaborators: John Merrill, M.D., *Boston*
Jacob Fine, M.D., F.A.C.S., *Boston*
Ernest K. Landsteiner, M.D., *Providence*

6:00-6:45 p.m. ***Reception,*** Foyer of Ballroom

6:30 p.m. ***Dinner,*** Ballroom Leland S. McKittrick, M.D., F.A.C.S., *Brookline,* Presiding

THE COLLEGE, AN INSTITUTION, RATHER THAN A SOCIETY
Paul R. Hawley, M.D., The Director

8:30 p.m. ***Medical Motion Pictures***

SURGICAL TREATMENT OF HIATAL HERNIA
Brian Blades, M.D., F.A.C.S., *Washington, D. C.*

HEMIGASTRECTOMY, VAGOTOMY AND GASTRODUODENOSTOMY IN THE TREATMENT OF DUODENAL ULCER, Robert J. Coffey, M.D., F.A.C.S., *Washington, D. C.*

SUBDIAPHRAGMATIC ABSCESS, Howard H. Bradshaw, M.D., F.A.C.S., *Winston-Salem*

FRIDAY, MARCH 4

8:30 a.m. ACUTE ABDOMINAL INJURIES (Medical Motion Picture)
Frederick E. Kredel, M.D., F.A.C.S., *Charleston*

9:30-12:00 noon Clinton R. Mullins, M.D., F.A.C.S., *Concord, N. H.,* Presiding

CONGENITAL ANOMALIES OF THE UROGENITAL TRACT
William J. Engel, M.D., F.A.C.S., *Cleveland*

ESOPHAGEAL HIATUS HERNIA . . . J. Murray Beardsley, M.D., F.A.C.S., *Providence*

ANORECTAL SURGERY . . . . Garnet W. Ault, M.D., F.A.C.S., *Washington, D. C.*

INDICATIONS FOR SPHINCTEROTOMY, Henry Doubilet, M.D., F.A.C.S., *New York*

SOME PERSONAL EXPERIENCES IN THE TREATMENT OF ABDOMINAL ANEURYSM . . . Robert R. Baldridge, M.D., F.A.C.S., *Providence*

FRACTURES OF THE EPIPHYSES . . Alexander P. Aitken, M.D., F.A.C.S., *Brookline*

1:30 p.m. PRECAUTIONS IN RESECTION OF THE COLON FOR CARCINOMA (Medical Motion Picture) . . . . . Warren H. Cole, M.D., F.A.C.S., *Chicago*

2:00-5:00 p.m. George Waterman, M.D., F.A.C.S., *Providence,* Presiding

AN APPRAISAL OF THE EFFICACY OF SURGICAL TREATMENT OF CANCER OF THE ESOPHAGUS . . . . . John H. Garlock, M.D., F.A.C.S., *New York*

SELECTION OF TREATMENT FOR BLADDER TUMORS
William J. Engel, M.D., F.A.C.S., *Cleveland*

ENDOCRINE ASPECTS OF CANCER MANAGEMENT
Danely P. Slaughter, M.D., F.A.C.S., *Chicago*

3:35-5:00 p.m.

THE USE OF THE MECHANICAL HEART-LUNG IN CARDIAC SURGERY
John H. Gibbon, Jr., M.D., F.A.C.S., *Philadelphia*

LARYNGEAL PARESIS AND PARALYSIS, Harold E. Harris, M.D., F.A.C.S., *Cleveland*

DIAGNOSTIC PROBLEMS IN THE CHEST, Julian Johnson, M.D., F.A.C.S., *Philadelphia*

8:30 p.m. ***Surgical Motion Pictures***

COMPLICATED APPENDICITIS . . . . James D. Rives, M.D., F.A.C.S., *New Orleans*

CARCINOMA OF THE THYROID . . . . . Richard B. Cattell, M.D., F.A.C.S., *Boston*

OPERATIONS FOR CORRECTION OF CONGENITAL BILIARY ATRESIA
Robert T. Tidrick, M.D., F.A.C.S., *Iowa City*

continued on next page

SATURDAY, MARCH 5

9:00 a.m. VOLVULUS OF THE SIGMOID COLON (Medical Motion Picture)
Harwell Wilson, M.D., F.A.C.S., *Memphis*

9:30 a.m.-12:00 noon Wilfred I. Carney, M.D., F.A.C.S., *Providence*, Presiding

SURGICAL DISEASES OF THE SPLEEN, Robert M. Zollinger, M.D., F.A.C.S., *Columbus*

THE GASTRIC ULCER PROBLEM . . . . I. S. Ravdin, M.D., F.A.C.S., *Philadelphia*

SPECIAL PROBLEMS IN PANCREATIC SURGERY
Richard B. Cattell, M.D., F.A.C.S., *Boston*

10:30 a.m.-12:00 noon *Panel Discussion — Biliary Tract Surgery*

Moderator: I. S. Ravdin, M.D., F.A.C.S., *Philadelphia*

Collaborators: Robert M. Zollinger, M.D., F.A.C.S., *Columbus*
Richard B. Cattell, M.D., F.A.C.S., *Boston*
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by
FRANK G. DICKINSON, Ph.D.
Director
Bureau of Medical Economic Research of the American Medical Association
at the
PROVIDENCE MEDICAL ASSOCIATION MEETING
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BOOK REVIEW

ALL CREATURES HERE BELOW by Joseph Garland, M.D., illustrated by Rene Martin. Houghton Mifflin Company, Boston, Massachusetts. $2.00.

The bookstore proprietor listed this book as suitable for the 9 to 12 year age. It is customary nowadays to tell those who wish to write for a large mass of the general public that they should write for the 14-year-olders, and the suggestion evidently is that they write down to the 14-year-olders. Dr. Garland has most certainly written up for the 9-year-olders. My wife intends to give a copy of this book to her 9-year-old nephew. I think he will enjoy it for he is destined to develop well beyond 14. I am sure that a 69-year-older would enjoy this book.

The clever editor of the NEW ENGLAND JOURNAL OF MEDICINE starts with his memories of the time when the earth was evolving from chaos; soon plant life developed followed by animal life. I see no reason why the spaceship travelers should not be greatly interested by the strange forms of animal life of those ancient days so well described by the author and delightfully illustrated by Rene Martin. Having given us this preliminary view, Dr. Garland then goes back for a running start and describes the different phyla or main groups of animals as they have developed through the eons from the amoeba and other single-celled animals up to the primates which latter includes Genus Homo or homo sapiens whom we are pleased to describe as the ultimate product of development.

I feel certain that all of you will find some most interesting details about these amphibians, reptiles, insects, and birds, to mention a few of these great groups. It is no easy matter to write so as to interest the intelligent 9-year-olds or the, we trust, equally intelligent, 69-year-older, but Dr. Garland has done this. I hope a lot of you look this book over.

PETER PINEO CHASE, M.D.



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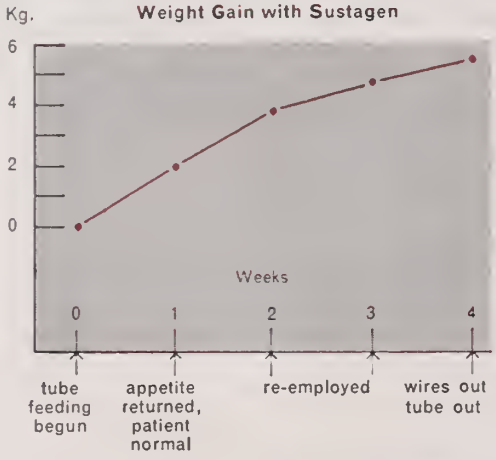
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Vitamin D	500 units
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Thiamine hydrochloride	10 mg.
Riboflavin	10 mg.
Niacinamide	100 mg.
Calcium pantothenate	40 mg.
Pyridoxine hydrochloride	5 mg.
Choline bitartrate	500 mg.
Folic acid	2.5 mg.
Vitamin B_{12} (crystalline)	4 mcg.
Iron (from ferrous sulfate)	15 mg.
Calcium	6.3 Gm.
Phosphorus	4.5 Gm.
Sodium	1.9 Gm.
Potassium	7 Gm.

Dilution for tube feeding:
1 cup Sustagen to 10 oz. water

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†Therapeutic Nutrition, Publication No. 234, National Research Council.

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Sustagen makes a pleasant tasting food drink. It can be used as a complete liquid diet or as a concentrated diet supplement for patients who cannot, or will not, take enough ordinary foods to meet their needs.

*Pareira, M. D.; Conrad, E. J.; Hicks, W., and Elman, R.: J.A.M.A. 156: 810, 1954.

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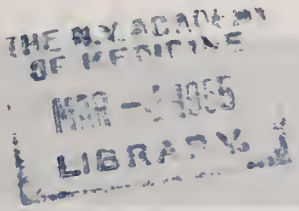
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See page 89





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References
(1) Kirby, W. M. M.; Waddington, W. S., & Doornink, G. M.: Antibiotics Annual, 1953-1954, New York, Medical Encyclopedia, Inc., 1953, p. 285.
(2) Finland, M., & Haight, T. H.: *Arch. Int. Med.* **91**:143, 1953.

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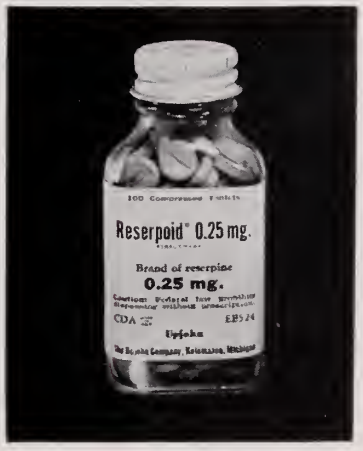
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1. Bargen, J. A.: Problems of Nutrition in Ulcerative Disease of the Digestive Tract, J. Michigan M. Soc. *53*:407 (Apr.) 1954.

2. Kirsner, J. B., and Sheffner, A. L.: Studies on Amino Acid Excretion in Man; VII. Effect of Various Protein Supplements in a Normal Man, Two Patients with Benign Gastric Ulcer and Two Patients with Chronic Ulcerative Colitis, J. Clin. Invest. *29*:828 (June) 1950.

3. Sappington, T. S., and Bockus, H. L.: Nitrogen Metabolism in Chronic Idiopathic Ulcerative Colitis and Its Therapeutic Significance, Ann. Int. Med. *31*:282 (Aug.) 1949.

4. Committee on Dietetics of the Mayo Clinic; Chronic Ulcerative Colitis: Dietary Program, in Mayo Clinic Diet Manual, ed. 2, Philadelphia, W. B. Saunders Company, 1954, pp. 59-62.

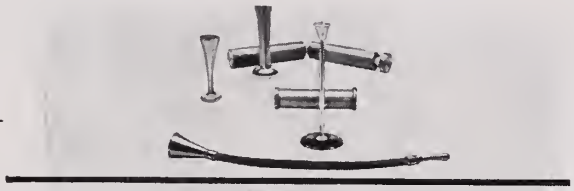
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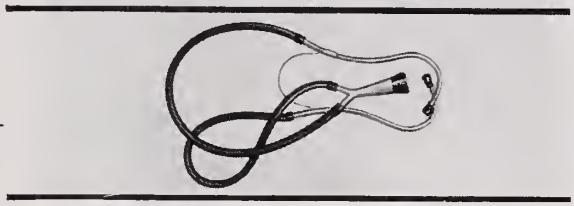
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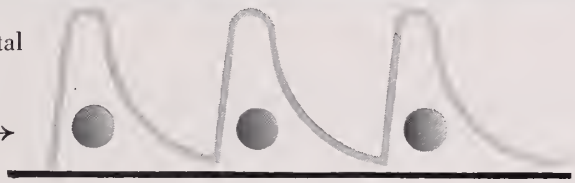
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PROVIDENCE RESCUE COMPANIES CITED

Remarks by Dr. William J. O'Connell, President of the Providence Medical Association, at the 108th Annual Meeting of the Association in making awards to the two Rescue Companies of the Providence Fire Department for their "Outstanding Community Service"

SINCE the Fire Departments of the State are generally well-equipped with necessary apparatus for rescue, and they are manned by personnel interested in safety, they have been increasingly called upon to render emergency service in our communities.

We, as physicians, know only too well the ramifications of emergency service to the general public. We, of all groups, recognize the difficulties in rendering community service in times of need, at disasters and accidents.

As an Association we have individually and collectively noted the outstanding service that has been given the people of the Greater Providence area by the Providence Fire Department through the service of its special rescue squads. There are few among us who have not had occasion to work with one of these units, to know how capably they are trained for their tasks, and how unselfishly they serve with little or no recognition for their work over and beyond their specified assignments as firemen.

On previous occasions our medical societies have given to each of the two rescue companies of the Providence Fire Department completely equipped physician's cases, as evidence of our support of their work.

In addition, members of our Association have joined with other physicians of the state in lecturing to Volunteer Fire Companies throughout the state under the auspices of the Committee on Rescue of the Governor's Fire Prevention Conference.

In the five years that our Medical Bureau has been in operation we have worked closely with the Rescue Units of the Providence Fire Department, and it is in recognition of their outstanding community service that we desire to pay them public tribute this evening.

On January 11, 1942, Rescue Company No. 1 of the Providence Fire Department was activated at the Central Fire Station.

In its first year of service this Company answered 254 calls. In 1954 its total runs numbered more than 1100. These figures alone do not present the story of the excellent work of the men of the Company in answering emergency calls ranging from child-births to fatal accidents. Their new truck, equipped with the finest equipment, is a familiar sight on our city streets, and only the victims of accidents and their families, and possibly we of the medical profession know the great community service that has been rendered.

The increasing demands of our large metropolitan area necessitated the establishment of a second unit, Rescue Company No. 2, on April 14, 1952. This second Company was placed in service at the Messer Street station, and to date it has responded to more than 2,150 calls.

With sincere appreciation for meritorious service, and with highest respect and esteem for their efficient handling of emergencies in our city during the past twelve years, the Providence Medical Association, on the occasion of this, its 108th Annual Meeting, publicly salutes the Providence Fire Department's Rescue Companies, and as an expression of "thanks" for a community service done in an outstanding manner, presents to each of the Rescue Companies an engraved silver plaque that reads as follows:

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of the

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by the

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In Recognition of

Outstanding Community Service

January 3, 1955

Lewis A. Marshall, Chief of the Providence Fire Department, has arranged for both Rescue Companies to be present here tonight, and as I call the names of the men I ask that they stand.

Rescue Company No. 1: Captain Frederick Badger, Edward Wilding, Frank O. Renfree, Earl C. Fuller, Manuel Sylvia and Donald Gibson.

Rescue Company No. 2: Lieutenant Arthur Brodeur, James E. Mahoney, Joseph B. Healey, John A. Bailey, Jr., Robert N. Drummond and Joseph R. Jansen.

I now ask Captain Badger and Lieutenant Brodeur to come forward and receive the citations for their companies.

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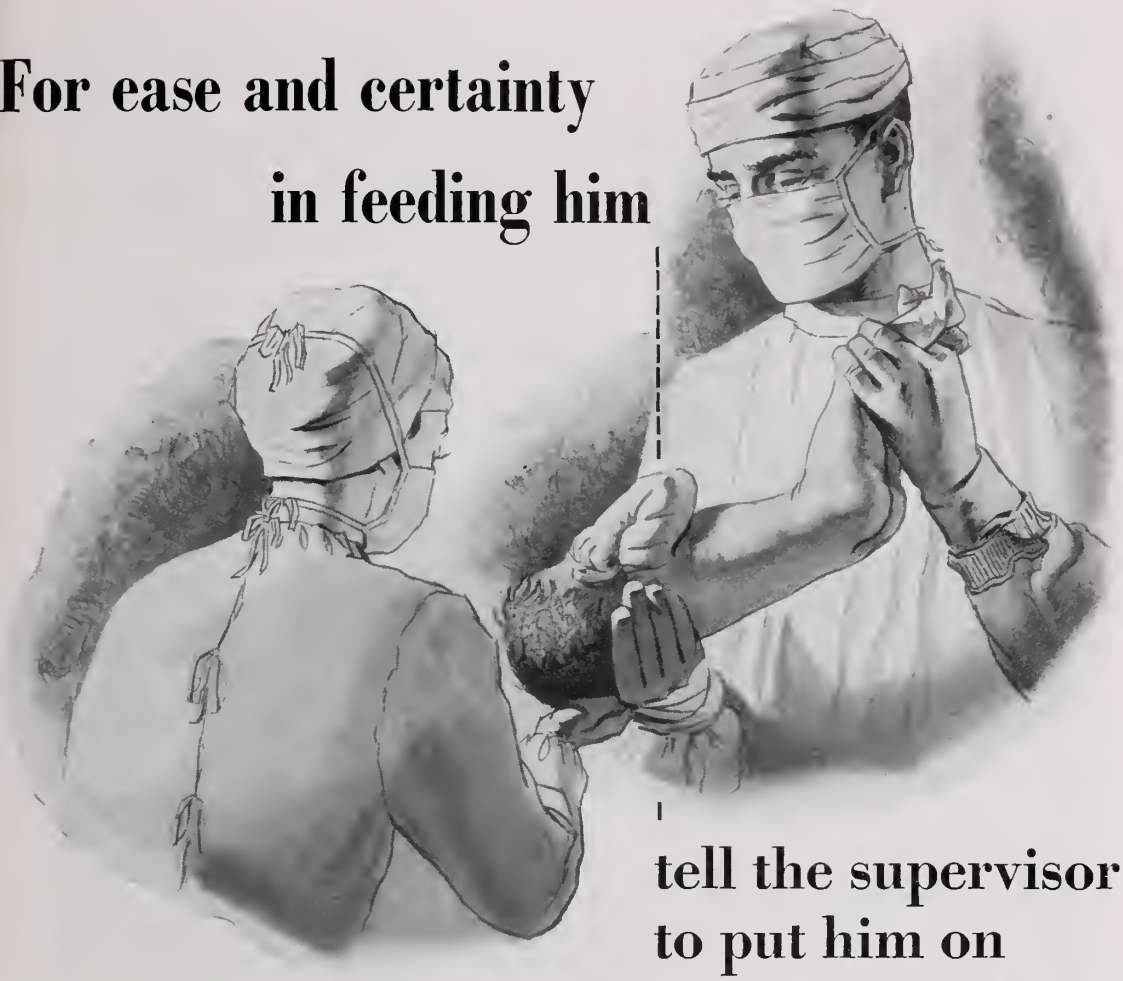


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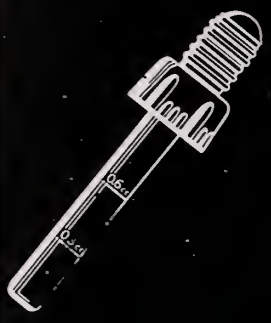


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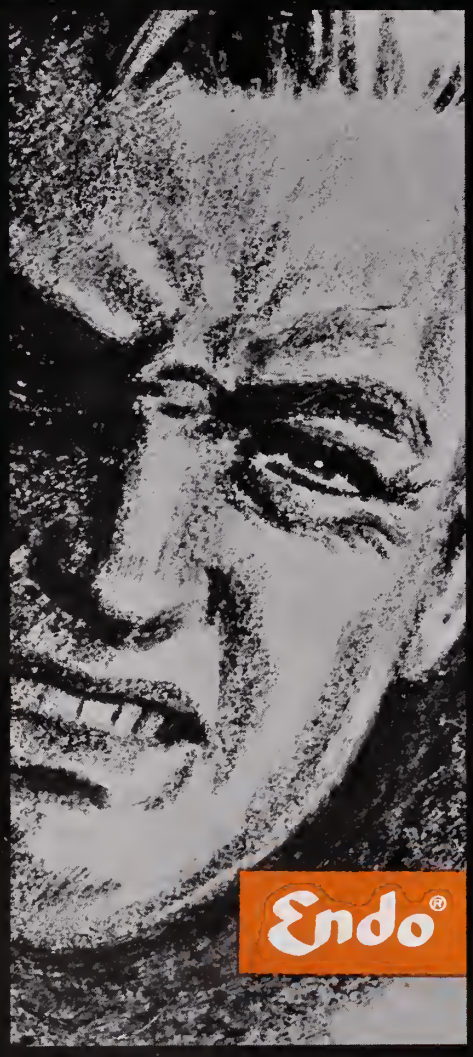
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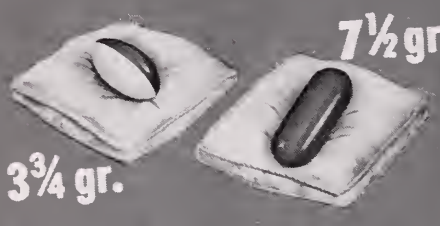
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXVIII FEBRUARY, 1955 NO. 2

THYROID CANCER AND NODULAR GOITER*

BENTLEY P. COLCOCK, M.D.

The Author. *Bentley P. Colcock, M.D., Department of Surgery, the Lahey Clinic, Boston, Massachusetts.*

As was pointed out in a recent article in the Bulletin of the American Cancer Society, the general practitioner is in a strategic position so far as the control of cancer is concerned, for he has the great advantage over his specialist and research colleagues of often seeing the patient at a time when cancer can be cured or even when it can be prevented. For this reason it is unfortunate that a certain amount of confusion has arisen in the minds of many medical men, particularly general practitioners, concerning the incidence of cancer of the thyroid and its relationship to nodular goiter. A number of statistical reviews have appeared in the literature, particularly in the Journal of the American Medical Association, purporting to show the low incidence of carcinoma of the thyroid, and the common occurrence of nodular goiter in the general population. It is implied that there is little significance to the presence of a nodular goiter so far as carcinoma is concerned and, in any event, carcinoma of the thyroid is so rare that it need scarcely be considered. These writers may not intend to convey these implications, but that they are being conveyed is evidenced by the questions being asked at state and county medical meetings.

The wide variation between the estimated incidence of carcinoma in the general population, and that reported by many surgeons interested in thyroid disease is explained on the basis of selection. It must be remembered that the patients of any physician represent a selected group. Patients coming to the Lahey Clinic do not come until the lump in their neck is of an appreciable size. If their neck is big and thick, the nodule may be 2 inches or more in diameter before it is noticed by the patient and he becomes sufficiently concerned to consult either us or his family physician. If the goiter is partly intrathoracic it may be considerably larger than that before he is even aware of its presence. As physicians, we are responsible not for the theoretical number of patients with cancer of the thyroid in the general population, but with the occurrence of cancer of the thyroid in the patients who come to see us. Inevitably, this will be considerably higher than the incidence of carcinoma in nodular goiter in the general population in which every person with any enlargement of the thyroid gland, no matter how slight, is included.

There is a definite relationship between carcinoma of the thyroid and nodular goiter. A nodule in the thyroid or an enlarged cervical lymph node is the only indication of cancer of the thyroid at a stage when it is curable. If a considerable number of patients with nodular goiter are seen, they will inevitably include an appreciable number of patients with cancer of the thyroid. As evidence to support this view, we can only present our own experience, which is not unlike that of other surgeons interested in thyroid disease. A year ago we reviewed all of the patients with thyroid disease whom we had seen during the two preceding years, 1951 and 1952. The diagnosis listed is the final diagnosis as confirmed by pathological section. There is little question that these diagnoses can be accepted as correct since all of the microscopic sections were reviewed by Dr. Shields Warren and Dr. W. A. Meissner of the New England Deaconess Hospital. Few pathologists in this country have had a more extensive experience in the diagnosis of thyroid disease.

During this two-year period, 1479 patients were seen at the clinic with various types of thyroid disease, and of this group, 78 or 5.3 per cent were found to have carcinoma. There is nothing unusual about these two particular years. The experience for 1953 and 1954 will be essentially the same.

The problem of thyroid carcinoma is the problem of nodular goiter. In this group of 1479, there were 447 patients with primary hyperthyroidism. Although occasionally carcinoma does co-exist with

continued on next page

*Presented at the Interim Meeting of the Rhode Island Medical Society, at the Pawtucket Golf Club, Pawtucket, Rhode Island, on October 27, 1954.

the hyperplasia of primary hyperthyroidism, the focus is usually small and all of these patients in our experience have been cured by the subtotal thyroidectomy, carried out for their hyperthyroidism. No patients with primary hyperthyroidism and carcinoma were seen during this two-year period. The same is true for the 93 patients with thyroiditis. Although carcinoma occasionally coexists with thyroiditis, no patient with both conditions was seen during this period.

Thyroid cancer is a problem not only of the nodular goiter; it is primarily associated with the nontoxic nodular goiter. During this two-year period there were 748 patients with nontoxic nodular goiter, and 113 patients with toxic nodular goiter. Seventy-six of the 78 patients who were found to have carcinoma did not have hyperthyroidism and only 2 patients had secondary hyperthyroidism associated with their nodular goiter. This is an incidence for carcinoma of 10.8 per cent in patients with nontoxic nodular goiter and only 1.8 per cent in those with toxic nodular goiter. Hyperthyroidism in a patient with nodular goiter does not rule out carcinoma but it does make its presence less likely.

The problem of thyroid cancer can be narrowed still further. It is primarily the problem of the solitary nodule. During this two-year period, 156 patients were found at operation, and on pathological examination, to have a solitary nodule in their thyroid. Fifty-two, or 33.3 per cent, had carcinoma. In this group of 52 cases, we do not know the number in which the carcinoma developed in a previously benign adenoma or the number in which the solitary nodule was carcinoma from the beginning. We must not, however, let argument about this point obscure the essential fact and that is, regardless of whether these 52 patients had carcinoma from the beginning or whether the carcinoma arose in a previously benign nodule in the thyroid, the malignant tumor cannot be distinguished from the benign tumor except by removal and pathological examination. I know of no way to distinguish with certainty a benign from a malignant nodule by palpation of the neck. The differentiation is difficult even by gross examination of the excised tissue at the time of operation. For this reason, we advise the removal of all nodules in the thyroid gland which appear to be solitary, regardless of the size of the nodule or the age of the patient.

Of the 78 patients with carcinoma, 57 were females and 21 were males. The ratio of females to males was approximately 8 to 3 or 3 to 1. This is not markedly different from the sex ratio in other types of thyroid disease. The age incidence in this group of patients with malignant disease emphasizes the fact that carcinoma of the thyroid is particularly prone to occur in young persons. Only 41 of the 78 patients were over 45 or in the so-called "cancer age." According to Pemberton and Black,[2] one third of all nodular goiters, singular or multiple, in children under 14 years of age, are carcinomas. Our experience at the Lahey Clinic is similar. Only 3 of the 78 patients had any symptom suggesting carcinoma, and in these 3 patients the symptom was hoarseness, certainly not pathognomonic of thyroid malignancy. Nine cancers were found on routine physical examination of patients who were quite unaware that they had any abnormality of their thyroid gland. Six patients were sent to us because of the unexpected finding of carcinoma at an operation for nodular goiter or because biopsy of a node in the neck showed papillary adenocarcinoma of the thyroid. In 2 patients, cancer of the thyroid was found because we advised biopsy of an enlarged cervical lymph node and in 58, the carcinoma was found in patients who came to the clinic because of a goiter. The 3 patients with hoarseness had far advanced malignant disease and have since died of their malignancy. Stubenbord and Noehren[3] were able to make a preoperative diagnosis of carcinoma in 24 per cent of their patients but they pointed out that all of the patients in this group were dead at the time of their report. We agree with Pemberton and Black that any real hope of materially improving the results in carcinoma of the thyroid using present known methods of treatment lies in removing the malignant nodule before it has spread or, for practical purposes, before symptoms suggestive of malignancy have made their appearance. Twenty-five of the 78 patients had known of the presence of the nodule in their neck for five years or more. This means that whether carcinoma arises in a previously benign nodule or is carcinoma from the beginning, a history of several years or more of the presence of a mass in the neck does not rule out cancer. Only 11 of the 78 patients had a preoperative diagnosis of carcinoma and 6 of these were sent to us because of a previous biopsy elsewhere. Carcinoma was suspected in 15 patients with a solitary nodule, and in one patient with multiple adenomatous goiter. Carcinoma was not even suspected in half of the patients in whom it was found.

There was no operative mortality in the 78 patients but all of the 11 patients with carcinoma recognized preoperatively are now dead of the disease. Thirty-seven or 47.4 per cent of the 78 patients with carcinoma had the papillary type, which is generally considered to be a relatively lower grade of malignancy. This is essentially the same incidence of the papillary type of tumor that we have found in the past. Winship and Chase,[4] reporting a group from the continent of Europe, found an incidence of papillary tumors of 22 per

concluded on page 86

THE DIGNITY OF THE PRACTICE OF MEDICINE*

WILLIAM J. O'CONNELL, M.D.

The Author. *William J. O'Connell, M.D., President, 1954, The Providence Medical Association, Providence, Rhode Island.*

IT IS CUSTOMARY for the outgoing president of this Association to deliver an address. In recent addresses, it has been stylish to talk of cleaning house, or to recommend ways and means to curb alleged rascality among the membership.

Since it has been the policy in recent years to have but one interesting speaker per evening, it enables me to abbreviate what is scheduled as a presidential address to a few pertinent remarks about the dignity of the practice of medicine.

Because we are subject to so much criticism, we tend to incriminate ourselves unjustly. I feel strongly, however, that understanding the patient plus developing an interest and sympathy to his problems and anxieties is perhaps the "somethingness" so often sensed and not satisfied that brings so much criticism to us.

We, ourselves, speak of rascality in fees when actually our charges are for the most part in keeping with the economic times. We glibly talk of sharp practices relative to compensation and insurance fees.

I wish to depart from this theme lest it lose its effectiveness by over emphasis.

Rather, I wish to note the world we live in, and observe, that because of the many social tasks placed upon us in modern living, we permit the spirit of unioneers to be unjustly attached to our humanitarian endeavors. We foolishly allow the public to make our services synonymous with goods, whereas, really our stock in trade is our time and our advice.

We fear socialized medicine, but we correctly, in the public interest, subsidize our work through Physicians Service and Blue Crosses, etc.

One cannot conceive of unionizing missionaries, and it is difficult to conceive of the government invading the sphere of the ministry, the priesthood or the temple. We, as physicians, certainly have much to be dignified about. Most of us, I am sure, have traveled the difficult road of medical training because of our desire to help our fellow man. There are many other pursuits of life that lead to greater financial gain with less anxiety than the long, hard, poorly compensated hours of the one hundred seventy-eight general practitioners in our Association and the many gratuitous hours the three hundred ninety-two specialists of our group spend in the hospital. We have turned to medicine because of the position the family doctor holds in the community—one of respect, and awareness that we are essential.

I feel that if we emphasize and advertise our humanitarian efforts, we too will have no more to fear than the ministry. Let me read to you, please, that wonderful tribute of Edith Parry Fisher, titled "Your Physician":

> "Nothing can take his place—not priest nor minister nor all the clinics that science can provide. There is a rapport and a confidence between him and his patient, which has been known to accomplish Miracles. For there's something about the very presence of the Family Doctor that casts out fear, melts apprehension, breaks down suspense, performs the simple miracle of Faith. We know how hard the life is that he's chosen. We know that he's abused, imposed upon, worn; that his days are not his own, and his nights are snatched and torn.
>
> And, we wonder, where are his rewards? What compensation is his? Oh, I think he is greatly repaid; greatly envied. His rewards are kingly prizes. The prize of welcome. That's a great reward. To have one's presence a blessing. To know that the mere sight of you brings heart's ease: stirs the weak pulse, brightens the fading eye.
>
> The prize of conquest. All men like winning against odds. To stay a fever; energize a pulse; throw breastworks against the advance of disease. Here, indeed, are paths of Glory that do not lead to the grave, but away from it. I cannot think of greater conquest.
>
> The prize of confidence. That's a proud possession. Some priests know it; some ministers; and friends, if they're time tried. But the family doctor is the final confessional, a refuge not only for repentent hearts, but sick hearts as well.

continued on next page

*Presidential Address delivered at the 108th Annual Meeting of the Providence Medical Association, at Providence, Rhode Island, January 3, 1955.

The prize of human wisdom—that deep knowledge that comes from being continually exposed to the pitiful frailties of mankind. You do not deceive the family doctor; you do not attempt to. But knowing you, he is still compassionate; for he has learned to expect little of greatness in his fellowman. Above all, I think I envy him his prize of selflessness. He is free, for he has already given up his life, so has nothing left to fetter him.

There is much talk of state control of medicine; and legislation dips its partial fingers into the sterile waters of our doctors, seeking to arbitrate over their mission of mercy. I dare say, there are certain restricted fields of medicine in whose confines the legislative hand could work productively. But the ineffable value of the human touch in medicine, is something that transcends all legislation.

What legislation indeed, what politics, what state control or organized social program can hope to substitute that Human bond that exists between the family doctor and his patients?" So wrote Edith Parry Fisher some twenty years ago.

We will not be judged great just because we are doctors, but because we go about doing good, because of our affection for human beings and our humble service to them.

May I recommend to the Membership that in addition to all the information in the daily press, the television, and the popular magazines and our medical literature that we, the Association, organize at the local level, information, to be published, broadcast, and televised about the dignity of the greatest profession on earth. Then, I am sure, the physician of today, will be as revered, as was the case two generations ago.

THYROID CANCER AND NODULAR GOITER

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cent and they thought that, because of their more careful grading of the tumors, their figure was more accurate than the higher incidence reported in this country. Pemberton and Black found an incidence of papillary tumor of 60 per cent. They pointed out, however, that because of local invasion, all of these more benign tumors eventually become nonresectable so far as complete removal of the tumor is concerned. We have repeatedly seen patients who had papillary adenocarcinoma in the primary tumor, but the secondary metastatic nodules in the lateral triangles of the neck and along the internal jugular vein were largely alveolar adenocarcinoma or even carcinoma simplex. Our present plan of treatment of carcinoma of the thyroid is to carry out total lobectomy with removal of the isthmus and adjacent portions of the opposite lobe, along with a radical neck dissection on the side of the tumor, for all patients with malignant adenoma with capsular or lymphatic invasion, for all patients with papillary adenocarcinoma and for all patients with alveolar or follicular adenocarcinoma. In cases of malignant adenoma showing no lymphatic or capsular invasion, total lobectomy without radical neck dissection may be done. We do not perform radical neck dissection in cases of carcinoma simplex, since the salvage rate is not sufficient to justify this more extensive procedure. These patients are treated by total thyroidectomy in so far as possible, followed by deep x-ray therapy. By carrying out routine radical neck dissection for the above indications regardless of whether lymph nodes were palpable, we found that 50 per cent of the 38 patients who had radical neck dissection showed metastases to the cervical lymph nodes. Deep x-ray therapy is given to all patients showing metastatic spread to the lateral cervical lymph nodes or local invasion.

All of these 78 patients have been operated on too recently to permit a follow-up study. In a follow-up study of an earlier group of 231 patients we found a five-year salvage ranging from 80 per cent in patients with papillary adenocarcinomas to 22 per cent for carcinoma simplex. Unfortunately, many of these patients with carcinoma of the thyroid who survive five years will not survive ten years. A recent report in the literature gave a 34 per cent five-year survival rate for patients with carcinoma of the thyroid, but only 24 per cent survived ten years. Another recent report[1] from the University of Pennsylvania gave a five-year survival rate of 52 per cent but also emphasized the high incidence of death from a carcinoma of the thyroid after five years.

Celsus in the first century A.D. made the statement that only the beginnings of cancer permitted a cure. A modern corollary to this was well expressed in a recent BULLETIN OF THE AMERICAN CANCER SOCIETY, "The early detection of cancer in the apparently well individual is the only protective procedure we have against cancer." In the case of cancer of the thyroid, we believe that necessarily means that we must, with certain exceptions, advise the removal of the nodular goiter.

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PRESENT STATUS OF MULTIPLE SCLEROSIS THERAPY

LAURENCE A. SENSEMAN, M.D., F.A.C.P.

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THE PURPOSE of this article is to inform the physicians of Rhode Island regarding the local chapter of the Multiple Sclerosis Society. This chapter has been organized by a lay group interested in multiple sclerosis and is under the leadership of Daniel McIver, himself a victim of the disease. It has been organized along the lines recommended by the national organization with headquarters in New York City. Our growing chapter has been fostering interest in multiple sclerosis in the state; conducting a fund raising campaign, establishing an interest in a clinic for multiple sclerotic patients and a general exchange of knowledge regarding this perplexing illness. A medical advisory board has been set up as recommended by the National Organization. The new Multiple Sclerosis Clinic at the Rhode Island Hospital, under the direction of Dr. William N. Hughes, meets on the first Saturday of each month in the Peter's House Auditorium and is free to any and all victims of multiple sclerosis.

The attention that the National Multiple Sclerosis Society has been focusing on multiple sclerosis is a valuable service to those afflicted with this disease as it brings new financial support; also scientists and research workers are becoming interested in this particular problem and are sponsoring special research projects, financed by the national organization.

Another purpose of this article is to strike an optimistic note regarding this disease which is so disabling to its victims. First of all, I would like to point out that there are some 200,000 to 300,000 multiple sclerotic patients in the United States. On the basis of population, this would be between 200 and 300 patients in the State of Rhode Island. As this illness attacks the third and fourth decades or the productive periods of life, it makes it more important for its early solution. At the present time, the life expectancy of a patient with multiple sclerosis approaches that of the population as a whole. It favors neither sex nor particular racial group but has been found to be more common in the northern latitudes of the temperate zone.

In a recent issue of the ANNALS OF THE NEW YORK ACADEMY OF SCIENCE,[1] there is one volume devoted to the *Status of Multiple Sclerosis*. Contributions made in this symposium represent the best thinking in regard to multiple sclerosis in America today, if not in the world. I should like to point out a few of the optimistic trends which are developing in the search for the solution of this particular problem.

In *Dynamics of Early Brain Disease with Particular Reference to Multiple Sclerosis*, Campbell,[2] very carefully points out that multiple sclerosis still offers some baffling problems as to its etiology but some most favored theories are: first, that it is a virus invasion which is most closely related to herpetic or western equine encephalomyelitis; second, that there is an endogenous antigen from within the nervous system which, with an unknown factor, will perhaps induce an allergic state; and third, that which interprets the disease as a consequence of allergic states which are built around exposure to antigens foreign to the body.

L. W. Freeman[3] has pointed out in an article that "regeneration of the spinal cord can and does occur." This is a new revolutionary idea which is indeed encouraging. He states further, "every patient with paraplegia who is intelligent and cooperative can be brought to a measure of medical, physical, and social rehabilitation compatible with a normal life expectancy." At the present time, this worker is using a drug called Piromen, which, if injected into the subarachnoid space, at the site of the lesion, may prevent the fibrous scarring similar to that which is known to occur in multiple sclerosis. His interesting experiment has not been corroborated by all workers in this particular field however.

Scheinker,[4] in a paper on circulatory disturbances points out that early plaque formation and the presence of vascular abnormalities is always found in early multiple sclerosis problems. Also, that a vaso-paralysis of the small blood vessels associated with stasis and congestion are among the

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essential factors in the pathogenesis of multiple sclerosis. He suggests that an elevation of the blood pressure and suitable medication for this, such as, Desoxyn, Ephedrin, Paredrin Hydrobromide plus Neo-Calglucon given intravenously along with calcium increases the tonus of the capillaries. He does not minimize the importance of muscle re-education and psychotherapy. The psychotherapy is intended to interpret to the patient that the disease is not hopeless but a challenge to be met by the combined efforts of the patient and the physician working as a team. He reports that out of 237 patients; 66.3% were complete or partial remission, 24% improved only slightly and only 24 cases were complete failures.

Another phase of importance is the finding by Walker et al[5] that several amino acids are missing from the cerebrospinal fluid in multiple sclerosis.

Volk et al[6] described a protein profile of the spinal fluid which he felt was of diagnostic value in multiple sclerosis. This may give us a positive diagnostic procedure which, in the future, will be very helpful to us.

Merritt et al[7] found that cortisone was not a suitable therapeutic agent in multiple sclerosis as it produces serious side-effects in some 20% of cases. However, others have found cortisone of some value in multiple sclerosis and have used it with varied success.

Another new drug which is being used in the field of multiple sclerosis therapy is muscle Adenylic Acid. This was worked out by A. Shapiro[8] and he has reported the results of therapy are encouraging though inconclusive.

Jones et al[9] have studied the metabolic characteristics of this disorder and have suggested some liver functions are impaired. As a result of these studies, they conclude that whole blood or human albumin therapy aborts a relapse in some patients. Even transfusions of blood and plasma have been suggested by Dr. Leo Alexander et al[10] and have proven of value in acute exacerbation of multiple sclerosis.

Leo Alexander,[11] of Boston, also has some interesting charts on patients, which point out that whenever the blood pressure rises spontaneously before, and/or during an attack of multiple sclerosis, the prognosis for this attack is good, but if the blood pressure is the same or falls during an attack the opposite results and the prognosis is not so good.

George Deaver[12] advocates physical rehabilitation and feels that the physical therapy is most useful in multiple sclerosis and he advocates massage which assists the muscle and blood flow. Also, hydrotherapy in the form of warm baths relieves pain and spasm. He also points out that exercise is most important; that is, active and passive movements overcome spasticity, contractures and prevents deformities. His rehabilitation program is aimed toward teaching the patient how to live in spite of his handicap. He states, "the best results are obtained by working with the patient instead of on him." He also points out, "action absorbs anxiety." I am sure we could all join with him in agreeing that "it is essential that physicians utilize all the methods available to help these unfortunate patients. If we, as physicians do not try every means possible to help them, we can expect them to seek help from other sources."

Marks[13] has pointed out some of the pharmacological agents used in this particular illness, some of which have been tried and many found useful but others have proved helpful only in varying degrees in individual cases. Some which would seem important are mentioned briefly here.

The vasodilators are helpful in modifying the allergic condition which is some times associated with multiple sclerosis. Histamine, he has found useful in arresting symptoms. This may be given by injection or by electrophoresis. Other dilators which have been tried are Amyl nitrate, Papaverine, Nicotinic Acid, Zenzazoline and most recently, Depropanex which is a pancreatic extract. Recently, studies have been made of the pancreas as it has been pointed out that in Joslin's thousands of cases of diabetes, only one with multiple sclerosis was found.

Anticoagulation drug (Dicumeral) has been found useful if it is begun as soon as activity in the disease appears but it should be carefully observed, blood testing done at frequent intervals and dosage regulated carefully.

Sympatholytic and adrenolytic compounds such as Etamon have been found only palliative in acute phases.

Circulatory stimulants have been used for too short a time for any conclusions to be drawn.

Some of the most widely used therapeutic agents are the vitamins, especially B_{12}, B_1 and B-complex. It is felt that these are good and should be used and their helpfulness in this illness is not denied.

Piromen, as previously mentioned, inhibits glial formation and stimulates axone regeneration, it is still in the experimental stage but may prove of real value in the future.

Marks[13] also listed a group of other drugs such as Adenosine (My-B-Den) which is now being used widely but needs further study for full evaluation.

Coenzymes offers a new and speculative field for investigation. Pancorphen needs critical evaluation but assists in the treatment of venular thrombosis. Wilder[14] reports 50% of patients with bladder symptoms improved.

Mephenesin reduces spasticity for a short time and, therefore, has limited therapeutic value, but is

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THE DOCTOR AND HIS INCOME TAX

II. Professional Income and Expenditures

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THIS, the second of two articles, is intended to cover in detail the professional income and allowable deductions of the medical profession which are reportable in Schedule C of the return, Form 1040, by those doctors who file their return on the cash receipts and disbursement basis, which is the accounting method used by practically all doctors. This schedule becomes the most important part of the doctor's return; although errors are made in reporting income, many physicians fail to properly deduct allowable expenses which are directly connected with their practice. It is very important that the data requested in the heading of Schedule C be furnished:

Owner's Name and Address

The name of the physician and his residence address must be clearly shown. Many times the schedule is inadequately attached to the return (1040) and because of this it becomes detached in the director's office; omission of the taxpayer's name and address on the schedule makes it difficult for his staff to associate it with the return from which it became detached; this results in additional correspondence and the request for the submission of a duplicate schedule.

(A) *Principal Business Activity*
Although it is not compulsory for the doctor to further clarify his profession other than doctor or physician; the inclusion of his specialty, if any, would in itself explain a large deduction for expenditures incurred which are necessary because of his particular specialty.

(B) *Number of Places of Business*
Most all practitioners maintain one office from which they pursue their practice, but I would recommend to those who also practice from their residence that both locations be shown, especially if deductions are made in the schedule for expenses sustained in connection with practice at the doctor's residence.

(C) *Did You Pay Social Security, etc.*
The answer to this question and that of (D) which follows are essential especially where a deduction is made by the doctor for wages and salaries on line 12 of the schedule.

(D) *Business Address*
The data requested is very important especially if the physician maintains his office away from his residence as it saves much time and effort, especially when the return has been assigned to an agent for a field audit by the Director of Internal Revenue; the agent will usually contact the physician at his place of business if such is indicated instead of writing or calling at his residence shown on page 1 of the return.

Professional Receipts (line 1)

Since the books of most members of the medical profession are kept on the cash basis, there should be included in this item all amounts received during the taxable year from patients, Physician Service, insurance and compensation fees, etc. There should not be included in this item any payments received from an industrial plant or other business when there exists any employer-employee relationship between the physician and those who pay him; a good test of this relationship is the withholding of social security contributions and income tax. The employer in this case will issue in duplicate, Form W-2, the original of which must be securely attached to the return, Form 1040, which is submitted to the director; such wages must be reported on page 1, line 2 of the return, never in Schedule C. A payer who does not issue a Form W-2 to the physician does so because he holds him to be an independent contractor, although at times errors are made. A good test of the employer-employee relationship is control of the services of the physician, direction as to the performance of his duties and other specific conditions which may be imposed with respect to the services rendered.

With respect to the receipts reportable on line 1 of Schedule C, it must be noted that the law requires

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everyone who pays $600.00 or more for services during the taxable year to report such payment to the Internal Revenue on Form 1099, a copy of which is usually sent to the person to whom it was paid. The original of the Form 1099, which is sent to the Treasury Department, eventually finds its way to the local office of the Director of Internal Revenue where it is associated with the taxpayer's return on file. I wish to note that some cases have come to light where the total of the amounts reported by those who paid the taxpayer has been in excess of the total receipts reported on line 1 of Schedule C. Many physicians have reported a large fee received in a current year for services rendered over a long period. The law provides that when a fee is received for services rendered over a period of thirty-six months or more and at least 80% of the fee for such services is paid in a taxable year, the physician may either include the full fee in his return for the current year, or he may allocate the fee over the taxable years in which the services were rendered; the allocation would in most cases result in a lower tax rate for the current year since the tax is computed at the rate in a lower bracket, as follows:

(1) Dr. William Hebron, was engaged to render professional services on April 2, 1951, by Henry Williams. Dr. Hebron rendered services from that date to July 30, 1954, the date of Mr. Williams' death. Immediately after, the executor of his estate paid Dr. Hebron a total of $12,000.00 which represented full payment for his services of 40 months (April 2, 1951 to July 30, 1954). Dr. Hebron would be permitted, if he so elected, to allocate the $12,000.00 to his income over the years in which the services were rendered, as follows:

Period of Service	*Number of Months*	*Allocation*	*Amount Allocated*	*Year*
April to Dec. 1951	9	9/40 of $12,000.	$2,700.00	1951
Jan. to Dec. 1952	12	12/40 of $12,000.	3,600.00	1952
Jan. to Dec. 1953	12	12/40 of $12,000.	3,600.00	1953
Jan. to Dec. 1954	7	7/40 of $12,000.	2,100.00	1954

(2) If Dr. Hebron elected to include the $12,000.00 in his total receipts in 1954, his tax would be considerably higher, especially if he had a large taxable income in that year.

A physician who has received such a fee for any of the prior years, 1953, 1952 or 1951 which he included in full in the year of receipt, may file an amended return and elect to allocate the fee. I would advise him to consult his tax adviser in order that a determination could be made as to whether a tax savings could be effected. With respect to 1951, it would be necessary to file the amended return on or before *March 15, 1955* since the statute of limitations for that year expires on that date.

Compensation for personal services is includable in income, even though not paid in cash. If services are paid with something other than money the fair market value of the article given in payment would be taxable income to the recipient, as follows:

(1) Dr. William O'Hearn, a surgeon, rendered a bill for services to Henry Quick for $200.00. Mr. Quick, later gave Dr. O'Hearn a painting which had a fair market value of $225.00 for which Dr. O'Hearn cancelled the indebtedness. Dr. O'Hearn would be required to include in his gross receipts $225.00. If he gave $25.00 to Mr. Quick, he would have constructively received $200.00 and would include that amount in receipts.

(2) Assume in (1) above, that Mr. Quick, who was a painter by trade, painted the kitchen and three bedrooms of Dr. O'Hearn's residence and because of this work, Dr. O'Hearn cancelled Mr. Quick's indebtedness. Dr. O'Hearn would be required to include $200.00 in his total receipts, as the cancellation of the debt by the doctor was because of services rendered by Mr. Quick. Mr. Quick would also be required to include $200.00 in his business income.

Material and Supplies (line 5)

This item is probably the one that is many times not correctly reported, as field examinations have disclosed that doctors during the course of the year make cash expenditures for supplies which they fail to include in their records.

It has been revealed in many examinations that doctors and other professional practitioners estimate the expense for material and supplies when filing their return; when an audit is made of the return, a tax deficiency usually results because of the taxpayer's failure to prove the total expense claimed. Other cases have been disclosed when doctors, especially general practitioners, who use medicines and drugs in connection with their practice, claim a deduction for materials and supplies which are not commensurate with the total receipts shown in the return, for example:

(1) Dr. Kenneth Smith, a general practitioner, uses quantities of drugs and serum in connection with the practice of his profession. His return disclosed a total receipts of $12,000.00 and deduction for such supplies of $3,600.00. Although the deduction may be correct in every respect, the return would probably be selected for a field examination because the ratio of 30% of total receipts for such supplies might be an error or highly inflated.

I wish to add that many doctors purchase serums and drugs while on the way to the office for which they pay cash, but upon their return to the office, they fail to notify the secretary of the expenditure, resulting in the loss of the deduction for the amount paid. The best solution to this problem is, do not pay cash; have the purchase charged and in this manner it will be recorded.

Salaries and Wages (line 12)

The professional practitioner is permitted to deduct all wages and salaries paid his employees; some doctors erroneously deduct only the actual take home pay of the employees which has been reduced by the required income tax and social security contributions withheld. When the doctor pays either his employees' income tax and social security contribution, he is permitted to deduct those pay-

ments as wages paid but, he must include these amounts in the employees' Form W-2, under gross wages paid, as follows:

(1) Dr. Mark Borod, during the year employed Miss Mary Sellers as his secretary, at a weekly salary of $40.00, and Miss Regina Silvers, a registered nurse, at a weekly salary of $60.00. If Dr. Borod deducted the income and social security taxes, his wage deduction would be as follows:

Employees	*Wages*	*Soc. Sec.*	*Income Tax*	*Take Home Pay*
Mary Sellers	$40.00*	$ .80	$5.00	$34.20
Regina Silvers	60.00*	1.20	8.70	50.10

*The wage deduction in this case would be $100.00

(2) If Dr. Borod did not deduct the social security and income tax from his employees' wages, his wage deduction would be as follows:

Employees	*Wages*	*Soc. Sec.*	*Income Tax*	*Total Wage Deduction*
Mary Sellers	$40.00	$ .80	$5.00	$45.80*
Regina Silvers	60.00	1.20	8.70	69.90*

*The wage deduction would be $114.70

It will be noted that not only is the doctor penalized in (2) above by a reduced annual wage deduction of $764.40 (52 x $14.70), but he is technically in violation of the revenue laws because of failure to correctly report the employees' wages on Form W-2, which results in the employees not paying the correct income tax.

A doctor is permitted to employ a member of his family, but there must exist an employer-employee relationship and the pay must not be excessive for the particular services rendered. A good test for the deductibility of such wage payment would be: "would the doctor pay a non-related individual the same wages for the services performed by his relative?" A doctor, who paid wages of less than $600.00 to a dependent would not be permitted a wage deduction on Schedule C for the services rendered by such dependent.

With respect to the taxable years previous to the advent of income splitting on the joint return of a husband and wife many business and professional taxpayers paid wages to their wives for nominal services performed in connection with their venture; the husband's net profit and tax bracket would resultingly be lowered by the amount of the wages paid his wife. Since this method of computing tax on joint returns became law the practice of paying salaries to wives has been practically eliminated. The payment to the wife would have no tax effect on their joint return, because the inclusion of the wife's wages on page 1, Form 1040, and the deduction of the wages on the husband's Schedule C would be a wash transaction.

The earnings of one who is claimed as a dependent *are not includable* in the return of the person claiming him as such. It would be appropriate to add that the earnings of a wife are always includable in the husband and wife's joint return. If the wife and husband file separate returns, the husband in this case would not be required to include his wife's income in his separate return, and he would not be permitted to claim her $600.00 exemption. The revenue laws do not classify a wife as a dependent.

Rental Payments (line 13)

A physician is permitted to deduct the full rent he pays for his office if none of the said premises are used as his personal residence. When the doctor maintains his office in the same building in which he resides, he is only permitted to deduct as rent that portion of the total rent he pays which is allocated to that portion of the building he uses as his office. This can be accomplished by the use of any of the following methods:

(1) The portion of rooms occupied as offices over the total number of rooms in the house, times the rent paid.

(2) The areas occupied as offices over the total area, times the rent paid.

(3) Determine from the landlord, if possible, the portion of his rent which should be allocated to the office and that portion to the residence.

When the doctor owns the premises which he uses, both for residence and professional office, he would be permitted to deduct expenditures for upkeep and depreciation to the extent of the portion allocated to the professional use as explained in (1), (2) and (3) above.

(1) Dr. Joseph Smith, maintained his professional office in the same building in which he resided with his family; he purchased the building in 1952. It was determined that ⅔ of the premises were used for professional purposes. Dr. Smith paid the following expenses for the property during the year. The full allowable depreciation each year would be $400.00, if it were used 100% for professional purposes. The deduction which Dr. Smith would claim in Schedule C is computed as follows:

City of Providence	$435.65	Depreciation	$400.00
Water	21.30	Repairs outside	120.35
Interest on mortgage	182.75	Painting outside	390.00
Insurance (1 Year)	93.50		
		Total	$1,503.55
Allowed as professional expense (⅔)			$1,002.36

The doctor would be permitted to deduct the above expenses either on line 13 as "Rental Expense" or line 22, "Other Business Expenses"; he would not be required to allocate the portion of taxes on line 14, the interest on line 15, and the repairs on line 19, etc.

A taxpayer, in a tax savings effort, purchased an office building which he subsequently transferred to a trust for the benefit of his children. The taxpayer transferred absolute control of the building to a disinterested trustee; the taxpayer in return pays rent to the trust for the office space he occupies in the building. The courts have ruled this to be a gift and lease-back to the taxpayer, but the Internal

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Revenue Bureau has consistently fought this setup, holding it to be nothing but a gift of rental income from the building to his children. If the taxpayer made an irrevocable gift of the fair market value of the building and land, and filed a gift tax return, he would then be permitted to deduct the yearly rent he paid his children for use of the office.

Many cases are on record where a group of doctors purchased a building which they occupy as professional offices, either in whole or in part, each of whom pays rent; this would be treated as a partnership and a partnership return, Form 1065, should be filed. This is nothing but an information return which discloses the portion of the profit derived by the partners; they must also include in their respective individual return on page 2, Form 1040, the partnership income, whether the profit was distributed or not. If the operation of such a building results in a loss, the loss may be deducted against other income on the partners' individual returns.

Interest Paid on Indebtedness (line 14)

The taxpayer is permitted to deduct on Schedule C, all interest paid during the year on all loans or purchases made in connection with his business or profession, regardless of what form of loan is used: the only condition is that there must be a legal obligation to pay interest. Any advance interest payments made during the year would be deductible in the year paid. A taxpayer who was ordered to pay a judgment for damages because of business or professional reasons would be permitted to deduct the interest paid if he borrowed the money to pay this judgment. A taxpayer would not be permitted to deduct in Schedule C any interest paid on personal loans, borrowings or life insurance, etc.

A doctor would be permitted to deduct as professional expense any identifiable interest paid with the purchase of equipment and office furniture used in connection with his practice. If the purchase price is payable in installments and the interest is not identified separately, the doctor would be permitted to compute the interest paid by adding each monthly balance, dividing by the number of months in which payments were made and multiplying the result attained by 6%. This procedure was explained in detail in the first article under the title *Interest Paid*.

Taxes Paid (line 15)

The doctor is permitted to deduct all taxes paid in connection with the practice of his profession. He may deduct taxes paid in the same manner as described with respect to interest paid (above).

Many doctors deduct as taxes the income tax withheld from the employees' gross wages, which is erroneous as it is paid by the employees.

The taxes paid on the automobile used for professional purposes are fully deductible under this category, but not the taxes on a second family auto, even though used by the doctor occasionally in his practice, as it is common sense to conclude that the doctor cannot drive two cars at one time. If the doctor used the second automobile exclusively for his practice such as transportation of patients, etc., he would also be permitted the tax deduction for this automobile.

No deduction is allowed with respect to manufacturer's excise tax paid upon the purchase of a new automobile for professional purposes, as it is part of the cost of the automobile and will be recovered by annual deduction for depreciation.

Losses on Business Property (line 16)

Deduction is permitted for those who have sustained a loss from a casualty which is directly related to the practice of the profession, none of which is compensated by insurance or otherwise. The deduction is permitted where such losses are sustained because of damage or destruction of an asset used in the professional practice which results from collision, fire, theft, flood, hurricane, lightning, etc. When the asset destroyed is used partly for business and partly personal, the deduction for the professional portion would have to be allocated to Schedule C, and the personal portion on page 3, Form 1040, if the taxpayer itemizes his deduction allocated to the portion used for professional and pleasure purposes. A physician who uses his automobile 100% for professional purposes would be allowed the full loss sustained, less any amount reimbursed by insurance; he would also be permitted to deduct any payments he made to any others for injuries or damages they may have received. Of course, if the automobile was used 100% for pleasure purposes no deduction would be allowed to the doctor in Schedule C; he would be allowed the deduction on page 3, but could not deduct any payments he made to others for damages and injuries they may have sustained, as follows:

(1) Dr. James Roe's professional automobile, which was not covered by insurance, was in a collision on January 12, 1954, with the auto of Mr. Henry Murray. Dr. Roe's auto was purchased on January 2, 1952, at a cost of $4,800.00; he had taken depreciation on the basis of a four-year probable life. At the time of the accident, it had a fair market value of $3,000.00. In addition, Dr. Roe paid Mr. Murray $2,800.00 for damages to his car and expenses sustained because of his injuries.

Dr. Roe would be allowed to take a deduction on line 15 of Schedule C as follows:

Date Acquired	*Cost*	*Life*	*Allowed Depreciation*	*Adjusted Cost*	*Fair Market Value Before Casualty*
1/12/54	$4,800.00	4 Yrs.	$2,400.00	$2,400.00	$3,000.00

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CANCER COORDINATING COMMITTEE

THE ACTION of the society in authorizing its cancer committee to take the initiative in forming a cancer coordinating committee in the state is commendable. The question has been discussed frequently that there is need for some sort of a mechanism to coordinate the work of the various agencies directly engaged in, or closely allied with, the problem of cancer control.

The committee of the society has for years carried forward an educational program for physicians, and has aided the Rhode Island Cancer Society in its various activities also. The General Assembly has increased its annual appropriation to permit expansion of the activities of the division of cancer control in the state health department. The department of social welfare has a direct interest through its public assistance division, and its control over convalescent and nursing homes. The nurses and dentists are closely allied with the overall planning for cancer control, and the department of education in the matter of cancer education.

It was fitting, therefore, that these various agencies assign representatives to a state-wide coordinating group to consider such broad matters as support of cancer research, compilation and use of statistical data, professional and public education, the establishment of clinics, detection programs, school and industry participation, volunteer services and financial aid to patients.

The responsibility for many of these matters undoubtedly will be quickly and effectively resolved. Others, requiring joint action and cooperation, will reach a better solution through the coordinated efforts of the appointed delegates who can establish general boundaries of responsibility that will enable their respective organizations to approach their tasks with the assurance of performing an even greater service to the public.

THE DOCTOR'S FEE

We have yet to meet anyone who does not freely admit that the cost of living has been on a continual rise in the past decade, and to a good measure wages have been steadily increased in most businesses.

We have yet to meet a doctor who has attempted, or even considered, an increase in his fees in proportion to the general economy of the times. Most men are getting the same fees for home and office visits that they have charged for years; our Physicians Service schedule of indemnities, drafted in the '40's is still continued as the payment for per-

continued on next page

sons within specified income groups; our schedule for wards of government, adopted several years ago, is still official, even though most of the governmental agencies do not meet nor even pay many of these reduced charges.

In his presidential address to the Providence Medical Association last month Dr. William O'Connell remarked that "there are other pursuits of life that lead to greater financial gain with less anxiety than the long, hard, poorly compensated hours of the 178 general practitioners in our Association and the many gratuitous hours the 392 specialists of our group spend in the hospital. We have turned to medicine because of the position the family doctor holds in the community—one of respect, and awareness that we are essential."

The fact that doctors are essential and at the same time have not used that factor to make excess demands upon the economy of the community for their personal services contrasts sharply with the action of the automobile workers at their economic and collective bargaining conference under CIO sponsorship in Detroit last November. Aside from the usual demand for automatic wage increases in 1955, and initial preparation for the demand of a guaranteed annual wage to give workers up to a year in which to find adequate jobs, the conference reported the adoption of the following:

> "The overtime proposal called for time-and-a-half for Saturday work, double time for Sunday work as such, and triple time for holidays worked. It carried unanimously.
>
> "The health security demand, endorsed by the conference with only one dissenting vote, insisted that companies pay the full cost of the 'hospital-medical package' in the same way they now pay the cost of pensions.
>
> "With employers carrying the cost of this program, said the Conference, they'd be more likely to join the Union in seeking better organized, more effective medical care programs. Under the current program, many doctors have boosted their fees so workers actually have insufficient coverage.
>
> "The Union proposal would provide for full company payment of hospital bills for each member and his family, including the extra charges now paid by the worker. Surgical and additional medical costs in hospitals also would be covered by the program."

No, the conference did not recommend that physicians be allowed to buy their automobiles at a lower cost than the rest of the public.

AMA COMES TO NEW ENGLAND

The task of conducting medical meetings, even at the state level, takes months of planning. In the case of the American Medical Association, with its annual session in June, and its Interim Session in December, the preliminary planning for future meetings is almost a continuous process.

It is approximately thirty years since an American Medical Association meeting has been held in New England. But time rights all inequities, and this year the physicians of the Northeast will have the opportunity of being hosts to the Interim meeting of the AMA to be held at Boston, starting Tuesday, November 29, and continuing through that week until Friday afternoon, December 2.

It has been traditional that the city and state in which the AMA sessions are held shall be host to the visiting groups. This year, however, all New England will participate, and on a regional basis the six states will equally share the honor with Massachusetts in planning the scientific program, and in entertaining the physician visitors from all parts of the country who will head for Boston the week end after Thanksgiving.

In planning for the meeting every Rhode Island physician is invited to submit suggestions regarding scientific papers, or scientific exhibits. Suggestions should be sent promptly to the Executive Office of the Society, to be forwarded to the New England planning committee which includes representatives from Rhode Island.

RESCUE SQUADS

The citation of the two rescue squads of the Providence Fire department for "outstanding community service" was a gesture that reflects anew the sincere appreciation of the physician to those who are allied with him in the unending task of meeting public emergencies.

Trained first as firemen, and subsequently for the special service with the rescue units, the men cited by the Association have made thousands of calls in answer to requests for emergency help. Like physicians, the firemen have also found that not all the calls for help are really emergencies, and many needless demands are undoubtedly made upon the fire department's special service.

The state now has fifty-four active rescue companies, all operated on a volunteer basis except for those in the metropolitan area of Providence. The majority of the companies have vehicles equipped with equipment with which to cope with any possible type of disaster. Both the Providence companies carry specially-equipped physicians bags, gifts of the Providence Medical Association and the Rhode Island Medical Society.

1955 POLIO VACCINE PROGRAM

On the assumption that the evaluation report on the 1954 poliomyelitis field trials to be issued about April 1 by Dr. Thomas Francis, Jr., of the University of Michigan, would justify the licensure of the vaccine by the National Institutes of Health, U. S. Public Health Service, nationwide policies for 1955 are being established.

Within the past month representatives of four leading national medical and health organizations and the federal government met with the National

Foundation for Infantile Paralysis to consider plans relative to the distribution and administration of the supply of vaccine now being purchased by the Foundation. Rapid application of the vaccine before the closing of schools and the onset of the peak polio season would be desirable to give protection to more children.

The consensus of the meeting on the subject has been set forth by the Foundation as follows:

1. That if and when licensed by the National Institutes of Health, the vaccine will be supplied by the National Foundation to state health officers in amounts sufficient to provide for the vaccination of
   a. Children who participated in the vaccine field trial in 217 field trial areas in the United States in 1954 but who did not receive vaccine at that time.
   b. All children enrolled in the first and second primary grades of all public, private and parochial schools in the continental United States, Alaska and Hawaii in the spring term of 1955.
2. The plan of administration of the vaccine in any state or territory will be the administrative responsibility of the respective state or territorial health officer and will be worked out by him in cooperation with the state or territorial medical society and state or territorial education officials.
3. The 1955 vaccine program has been initiated by the National Foundation for the purpose of making possible early and widespread application of a newly established preventive measure against paralytic poliomyelitis; after completion of this program, the National Foundation will not participate in the production, distribution or administration of poliomyelitis vaccine.
4. The children in the first and second grades of primary school were selected for the program because of the high incidence of paralytic poliomyelitis in this group and their accessibility as organized units within the schools, keeping in mind the limitations on the amount of vaccine to be available for this program.
5. It is expected that additional vaccine, equivalent or greater in amount than that contracted for by the National Foundation, will be obtainable through usual commercial channels for the use of private physicians for their patients.
6. Vaccine for use in 1955 will be administered on the same dosage schedule as was followed in the 1954 field trial, namely 1 cc. of vaccine in each of the three doses, given intramuscularly, the second inoculation one week after the first and the third inoculation four weeks after the second.
7. Administrative procedures for the giving of the vaccine will be as simple as possible and will not require extensive record-keeping. Except in those states which wish and are in a position to conduct follow-up studies, no extensive nationwide evaluation such as was done in the 1954 field trial is contemplated.
8. Upon request from state health officers, the National Foundation will supply educational and other printed materials for use in the conduct of the vaccination program and will provide local cooperation and assistance through its chapters in all counties as requested by local health authorities.

YOU ARE INVITED

The Advisory Committee on Arrangements for the Section Meeting of the American College of Surgeons, to be held at the Sheraton-Biltmore in Providence on March 3-4-5, extends an invitation to every member of the Rhode Island Medical Society to attend the meeting.

The members of the local Advisory Committee are: Doctors Henri E. Gauthier, Chairman; J. Murray Beardsley, James C. Callahan, Wilfred I. Carney, Hartford P. Gongaware, Arthur E. Hardy, Robert T. Henry, Waldo O. Hoey, John P. Jones, Alfred L. Potter, Orland F. Smith, John G. Walsh, John F. Streker, Eske K. Windsberg.



Providence Journal-Bulletin Photo

FOR OUTSTANDING COMMUNITY SERVICE

Dr. William J. O'Connell, President of the Providence Medical Association, presents silver plaques to the Providence Fire Department Rescue Companies. From left to right: Lt. Arthur Brodeur, Rescue Company 2; Capt. Frederick Badger, Rescue Company 1; Dr. O'Connell, and Fire Chief Lewis A. Marshall.

THE DOCTOR AND HIS INCOME TAX

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Casualty Loss on Automobile	$2,400.00
Damage Paid Mr. Murray	$2,800.00
Deductible Loss	$5,200.00

(2) If the automobile was the personal car of Dr. Roe, and Dr. Roe was on a pleasure trip at the time of the accident, he would not be permitted the deduction on line 15 of Schedule C, for either the damage to his car or the amount paid Mr. Murray, as the collision did not occur while the doctor was operating the automobile in connection with his professional duties; the loss would be deductible on page 3 of Form 1040 as personal loss, but the payments for damages to others, would not be deductible.

Depreciation (line 18)

All business and professional assets which have a useful life of more than one year are subject to allowance for depreciation which permits an annual deduction against business income. The depreciation for the allowance is determined by dividing the cost of the asset by the number of years of its estimated useful life, or 100% divided by the number of years, which will result in the percentage of its cost that may be deducted each year it is in use. The taxpayer is not permitted under law to take advantage in later years of his failure to take a proper depreciation in prior years; the law provides in this respect that depreciation is that which is "allowed or allowable"; therefore, it is very important that the proper determination of the life of an asset be made in the first year of its use. *When* there is a major improvement made to an asset which prolongs its life it would be necessary to estimate a new period of life because the improvement, in most cases, would extend its useful life. There follows a fair estimate of the useful life of business and professional assets which are acceptable as fair by the Internal Revenue Service:

Kind of Property	*Life in Yrs.*	*Kind of Property*	*Life in Yrs.*
Frame building	33⅓	Office	10
Frame and stucco bldg.	40	Physiotherapy	10
Brick building	50	Automobile	4
X-Ray	10	Library	10
Instruments	10	Scale	15

I wish to note that the above life estimates are based on normal use of equipment; when there is an abnormal use or a sub-normal use of the asset, the life may be decreased or increased respectively.

(1) *Straight Line Method.* This method is also known as the regular method; the depreciation is determined by dividing the cost of the asset by the number of years of its useful estimated life.

(2) *Declining Balance Method.* This method has been in use in the past except that under previous law, it permitted the taxpayer to deduct 150% of the depreciation allowed by use of the straight line method; the new code has increased this percentage to 200%. The following examples demonstrate the use of the straight line and the declining balance methods:

(1) Dr. Mark Williams on January 10, 1954 purchased new equipment for his office and waiting room at a cost of $10,000.00. Dr. Williams estimated the useful life of these assets as ten years, beginning in January of 1954. Dr. Williams would be permitted to deduct yearly the following depreciations during the ten years they are in use. The doctor may use whichever method he finds best.

	Straight Line (10%)	*Declining Balance (20%)*	
Year	*Depreciation*	*Balance Beginning of the Year*	*Depreciation 20% of Balance*
1st	$ 1,000.00	$10,000.00	$2,000.00
2d	1,000.00	8,900.00	1,600.00
3d	1,000.00	6,400.00	1,280.00
4th	1,000.00	5,120.00	1,024.00
5th	1,000.00	4,096.00	819.20
6th	1,000.00	3,276.80	655.36
7th	1,000.00	2,621.44	524.28
8th	1,000.00	2,097.66	419.43
9th	1,000.00	1,677.73	335.55
10th	1,000.00	1,342.27	268.45
Total	$10,000.00		$8,926.27

Please note that under the straight line method, Dr. Williams recovers through depreciation his full cost of $10,000.00 over the ten years of estimated useful life, whereas under the declining balance method, there remains an unrecovered cost balance of $1,073.73. ($10,000.00 less $8,926.27.) Dr. Williams would be permitted a depreciation deduction of $357.91 (⅓ of $1,073.73) if he estimated the remaining life of the equipment for three more years.

(3) *Sum of Digits.* This is an entirely new concept with respect to deduction for depreciation which was put into effect by the 1954 code. Under this new method, the doctor would total the digits in the period of estimated useful life. For instance, if the estimated useful life was determined to be 5 years, he would add 1, 2, 3, 4 and 5 which would total 15; the depreciation deducted each year would be 5/15 of the cost in the first year, 4/15 the second year, 3/15 the 3d year, etc.

(1) Dr. Mary Silva, on January 11, 1954, purchased at a cost of $3,000.00, a new automobile which was in use 100% in connection with her professional practice. Dr. Silva estimated its useful life to be 4 years and she elected to use the sum of digits method as follows:

Cost of automobile	*Life*	*Sum of digits*
$3,000.00	4	10

Year	*Allocated Portion*	*Cost*	*Depreciation*
1st	4/10	$3,000.00	$1,200.00
2d	3/10	3,000.00	900.00
3d	2/10	3,000.00	600.00
4th	1/10	3,000.00	300.00
		Total	$3,000.00

Under this method the full cost of the asset would be recovered over the estimated useful life.

I wish to add that the accelerated methods (2)

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MICTINE*—THE NEW ORAL DIURETIC

Searle MICTINE Provides Effective Oral, Non-Mercurial Diuresis

The result of many years of research, Mictine, brand of aminometramide, supplies a long-felt need for an improved oral diuretic. Mictine, 1-allyl-3-ethyl-6-aminotetrahydropyrimidinedione, is not a mercurial, xanthine or sulfonamide.

Effectiveness: Every method for measuring the diuretic effect in man now available, including precise human bioassay studies, without exception demonstrated that Mictine is an effective oral diuretic, and these studies show that approximately 70 per cent of *unselected* edematous patients treated with Mictine by mouth respond with a satisfactory diuresis.



Mictine is believed to act by the selective inhibition of the reabsorption of sodium ions. Thus, the resulting diuresis is characterized by increased quantities of sodium ions and water.

Well-Tolerated: There are no known contraindications to Mictine, even in the presence of hepatic or renal damage, and there is no risk of acidosis. On high dosage, Mictine causes some side effects in some patients but on three tablets daily these side effects (anorexia and nausea, rarely vomiting, diarrhea or headache) are minimal or absent.

Indications: Mictine is useful primarily in the *maintenance* of an edema-free state and in the *initial and continuing* control of patients in mild congestive failure. Mictine may be used also for *initial and continuing* diuresis in *more severe* congestive states, particularly when mercurial diuretics are contraindicated.

Administration: The usual dosage for the average patient is one to four tablets daily with meals, in divided doses on an interrupted schedule. An interrupted dosage schedule may be accomplished by giving the drug on alternate days or for three consecutive days and then omitting it for four days.

For severe congestive states the dosage is four to six tablets daily with meals, in divided doses on interrupted schedules similar to those already mentioned.

Supplied: Uncoated tablets of 200 mg.

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SEARLE

THE DOCTOR AND HIS INCOME TAX

continued from page 96

and (3) would be more advantageous for a doctor who has been in practice and has a substantial profit from the practice of his profession. The higher depreciation deduction would substantially reduce his tax in the earlier year of estimated life, whereas it would be more advantageous to a physician who has just begun practice to use the straight line method.

There is a limitation with respect to the use of the new depreciation method, namely the "sum of digits," and that is the asset must have:

(a) A useful life of three years or more
(b) Its original use began with the taxpayer after March 31, 1953
(c) It must be a *new* and not used asset.

The taxpayer elects use of this method in his first return and is not required to request permission for its use; he may not use this method with respect to assets held previously.

With respect to the declining balance method, the taxpayer may elect its use at twice the straight line rate by computing his depreciation for the first year, ending after December 31, 1953.

As stated previously, with respect to the apportionment of allowable deductions in those cases where doctors use the premises both for offices and residence, the depreciation will be allowable to the extent of the portion of the premises so occupied for professional purposes as follows:

(1) Dr. William Mercoid purchased real estate on January 10, 1954 at a cost of $32,500.00, of which $22,500.00 was allocated to the building, and $10,000.00 to the land. Dr. Mercoid occupied the premises for both professional and residential purposes which was correctly determined to the 60% business and 40% residential. The life of property was determined to be 25 years. His depreciation would be computed as follows:

Cost of Building	*Life*	*Rate*	*Deductible*
$22,500.00	25 yrs.	$900.00	$600.00

The remaining one-third would be treated as the personal use portion and not deductible.

(2) If Dr. Mercoid also maintained offices in another downtown building which he owned, he would be allowed the full depreciation in addition to that computed in (a) above.

It is most important that the doctor be prepared to show that he performs substantial professional services in the premises in which he resides if he maintains another office at a different location; the mere fact that he might occasionally see a patient at home would not warrant a deduction for the proportionate depreciation together with other expenses such as light, heat, telephone, etc.

Repairs (line 19)

Expenditure for repairs to business property and professional equipment may be deducted in the year in which paid, providing that the expenditure is to keep the asset in efficient operating condition and does not in any way prolong the life of the asset. Many taxpayers erroneously deduct as repairs in Schedule C payments which are not repairs, but are mainly improvements to the asset which materially prolong its useful life, for example:

(1) Dr. William Bowen, in 1954, replaced the old motor in his professional automobile, at a cost of $500.00; in addition, he expended an additional $200.00 for new upholstery and new equipments. Dr. Bowen would not be permitted to deduct the $700.00 as repairs in 1954, since he had made an improvement to his professional auto which materially prolonged its useful life.

(2) If Dr. Bowen made repairs to his engine and other equipment at a cost of $700.00, he would be permitted the deduction in 1954.

Many professional practitioners purchase real estate for the purpose of converting it to professional offices with a view of occupying a portion and renting the remainder; any amount expended on it immediately after purchase would be treated as improvements, since the selling price of the property would be greater if such expenditures were made by the seller. When expenditures are made both for legitimate repairs and improvements, the Revenue Service would permit a portion of the amount paid as a repair deduction.

Replacement of small parts for the professional automobile and equipments which are made in order to keep them in operating condition would be deductible as repairs. Tires and tubes for the doctor's automobile would also be treated as a repair expenditure and deductible in full in the year in which the purchase price was paid. There follows herewith, expenditures made to professional building and equipment which are treated as repairs and others which are construed to be capital improvement:

Repairs	*Improvements*
Paint	Storm windows
Floor surfacing	Floor (new)
Boiler	Boiler (new)
Walls	Walls (new)
Roof and gutter	Roof and gutters (new)
Plumbing	Plumbing (new)
Radiator	Radiator (new)
Water pipes	Water pipe (new)
Carpenter	Additions (new)

Other Professional Expense (line 22)

This category is the catch-all for other expenditures not otherwise identified by lines 12 to 19 inclusive. A breakdown of the expenditures should be reported in Schedule C-2 of Schedule C. When the itemized expenditures are larger in number than the space available in Schedule C-2, the doctor should attach a schedule to the return which should be identified as "Schedule C-2 — Explanation of amount claimed on line 22—Schedule C," and he should then enter in Schedule C-2—"see Schedule attached." Among the expenditures deductible in line 22 are the following:

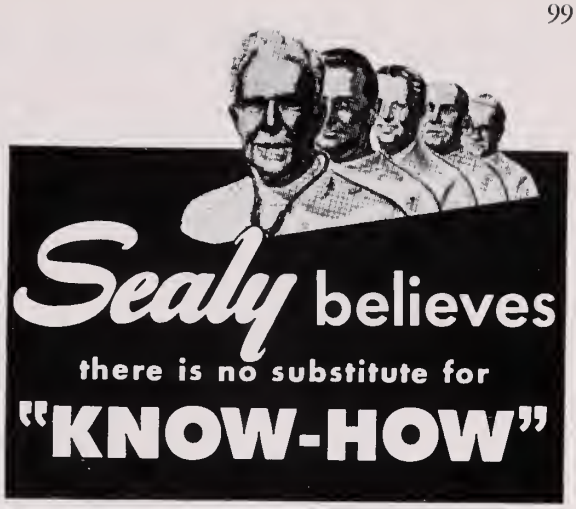
Electricity	Automobile insurance
Auto expense (1)	Liability insurance (office)
Telephone service	Stamps, stationery
Exchange service	Magazines (professional)
Laundry	Rubbish removal
Water	Professional books (2)
Cleaning	Small instruments (4)
Entertainment expenses (3)	Professional association dues
Nurses uniforms	Cost of attending conventions (5)
Doctors uniforms	Club dues (6)
Collection agency fees	Party for employees
R. I. annual fee	Professional assistants' fees (7)
Miscellaneous expense (8)	
Professional liability insurance	

(1) *Auto expense.* This is the expenditure which most doctors fail to report correctly because of failure to keep an accurate record of cash expenditures while on the road; this results in an additional tax burden because of failure to report the correct allowable deduction for automobile. I would recommend that the doctor maintain one or more charge accounts with gasoline companies and in this manner he will have a complete record of all expenditures for his automobile. Please note that a doctor who operates exclusively from his office, has no hospital service and makes no calls on patients, would not be allowed a deduction for automobile expense. The expense of travel from a doctor's home to his office is also not deductible as professional expense.

(2) *Professional books.* A doctor would be required to depreciate his medical library over the period of its useful life which in most cases is from three to five years, but a doctor who purchased professional books which might have a short life of one year or less, would be permitted to deduct the full cost in the year of purchase.

(3) *Entertainment expense.* This is one of the most controversial of all deductions by the professional practitioner. I have always maintained that a doctor who practices a specialty would be permitted a deduction for entertainment expenses since his income is dependent on referrals by his colleagues. The deduction must be substantiated by records and data, both as to the place where the expenses were incurred, the amount expended and other supporting data which would establish the merit of the expenditure. Of course, in the case of a general practitioner it would be more difficult to prove the necessity or the reason for the expenditure, since such a practitioner would be placed in the same position as a buyer who claims a deduction for expenses sustained in connection with the entertainment of a salesman; it is common business practice that the salesman usually entertains the buyer in order to maintain his good will.

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DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

The 108th Annual Meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, January 3, 1955. The meeting was called to order by the President, Dr. William J. O'Connell, at 8:40 P.M.

Annual Report of the Secretary

Dr. Michael DiMaio, Secretary, read his annual report for 1954, which was received and placed on file.

Annual Report of the Treasurer

Dr. Robert G. Murphy, Treasurer, read his annual financial report for 1954, which was received and placed on file.



FRANCIS H. CHAFEE, M.D.
President, 1955
THE PROVIDENCE MEDICAL ASSOCIATION

Report of the Executive Committee

The Secretary reported the following actions by the Executive Committee:

1. It agreed that the Association should cooperate with the American Medical Association in the proposed closed circuit television programs presenting scientific material for physicians.
2. It received and approved the financial report of the Association for 1954 as presented by the Treasurer.
3. It adopted a proposed budget for 1955.
4. It voted that the dues for 1955 be $20 for active members and $5 for associate members.
5. It approved the appointment of a committee on by-law revisions as named by the President.

Action—It was moved that the report of the Executive Committee and the recommendations incorporated therein be approved and adopted. The motion was seconded and carried.

Presidential Address

Dr. William J. O'Connell delivered his Presidential Address on the subject of "The Dignity of the Profession."

Award of Membership Certificates

The President awarded a certificate of active membership in the Association to Dr. Ivan Basilevich of the State Hospital for Mental Diseases. A certificate was awarded, in absentia, to Dr. Charles J. Hutchinson of Andrews House, Brown University.

Applications for Membership

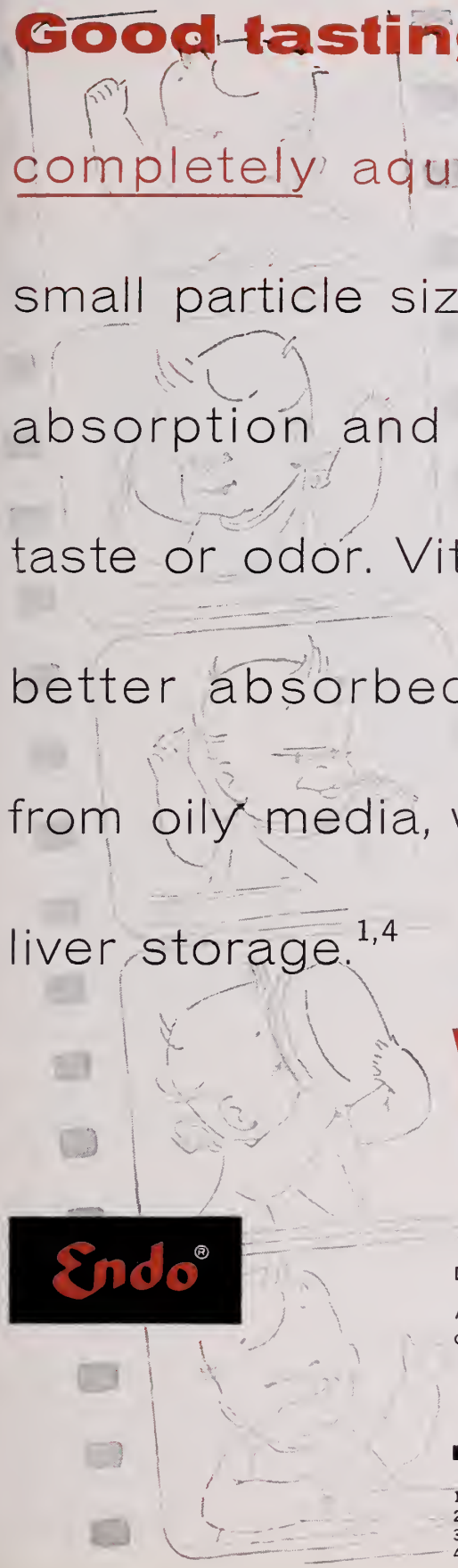
The Secretary reported that the Executive Committee recommends the election to active membership of: Dumitru Caramiciu, M.D., 156 Elmwood Avenue, Providence; Leo Richard Licis, M.D., State Hospital, Howard; and to associate membership of: Alton P. Thomas, M.D., Woonsocket; and Oscar E. Stapans, M.D., Saylesville.

Action—It was moved that the nominees for active and associate membership be elected. The motion was seconded and adopted.

Election of Officers for 1955

The Secretary reported that there had been no counter-nominations to the slate of officers nominated by the Executive Committee and submitted to the membership in advance of the annual meeting.

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1. Sobel, A. E., et al.: Am. J. Dis. Child. 80:932, 1950.
2. Davidson, D. M., and Sobel, A. E.: J. Invest. Dermat. 12:221, 1949.
3. Gribetz, D., and Kanof, A.: Pediatrics 7:632, 1951.
4. Sobel, A. E., et al.: J. Nutrition 35:225, 1948.

PROVIDENCE MEDICAL ASSOCIATION

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Action—It was moved that the slate of officers and delegates to the Rhode Island Medical Society nominated by the Executive Committee be elected to serve the Association until the next annual meeting. The motion was seconded and adopted.

The slate elected is as follows:

President ..... Francis H. Chafee, M.D.
Vice President ..... Robert R. Baldridge, M.D.
Secretary ..... Michael Di Maio, M.D.
Treasurer ..... Robert G. Murphy, M.D.
Councillor to Rhode Island Medical Society
(2 year term) ..... William J. O'Connell, M.D.
Trustee of R. I. Medical Library
(1 year) ..... Herbert G. Partridge, M.D.
Executive Committee (3 year terms)
William J. O'Connell, M.D.
Edmund B. Curran, M.D.

Delegates to the House of Delegates of the Rhode Island Medical Society:

Charles J. Ashworth, M.D.
Robert R. Baldridge, M.D.
Irving A. Beck, M.D.
Alex M. Burgess, Jr., M.D.
Frederic J. Burns, M.D.
Wilfred I. Carney, M.D.
Francis H. Chafee, M.D.
William B. Cohen, M.D.
Edmund B. Curran, M.D.
John A. Dillon, M.D.
Michael DiMaio, M.D.
William J. H. Fischer, M.D.
J. Merrill Gibson, M.D.
John C. Ham, M.D.
Hannibal Hamlin, M.D.
Albert H. Jackvony, M.D.
Ernest K. Landsteiner, M.D.
Robert G. Murphy, M.D.
William S. Nerone, M.D.
Arnold Porter, M.D.
Alfred L. Potter, M.D.
William A. Reid, M.D.
Louis A. Sage, M.D.
Lee G. Sannella, M.D.
William J. Schwab, M.D.
Linus A. Sheehan, M.D.
James J. Sheridan, M.D.
George W. Waterman, M.D.
Vincent Zecchino, M.D.

Introduction of New President

Dr. O'Connell appointed Dr. William P. Buffum and Dr. Robert R. Baldridge to escort the new President, Dr. Francis H. Chafee, to the rostrum. Dr. Chafee expressed his appreciation for the honor conferred upon him and stated that with the assistance of the membership he hoped to maintain the lively interest shown by the organization during the past year in the various professional and community activities. He then expressed the appreciation of the Association to Dr. O'Connell for his excellent leadership during 1954, and he presented him with an engraved gavel as a gift from the Association.

Dr. O'Connell briefly thanked the officers and members of the Association and the executive office staff for the invaluable assistance rendered him during his tenure of office.

Dr. O'Connell introduced to the membership the other officers elected as follows:

Robert R. Baldridge, M.D. ..... *Vice President*
Michael DiMaio, M.D. ..... *Secretary*
Robert G. Murphy, M.D. ..... *Treasurer*
Herbert G. Partridge, M.D.
Trustee, R. I. Medical Library
Alfred L. Potter, M.D.
William A. Reid, M.D.
John C. Ham, M.D.
Thomas L. Greason, M.D.
Executive Committee

Reports of Committees

The President announced that reports of committees, as filed with the Secretary, will be submitted for publication in the RHODE ISLAND MEDICAL JOURNAL. He offered any committee chairman the opportunity to bring any special recommendation before the membership. No recommendations were made.

Announcement by the President

Dr. O'Connell announced that an obituary committee consisting of Drs. William J. O'Connell and Wilfred I. Carney had prepared the Association's tribute to the late Dr. Remington P. Capwell and the tribute had been placed on file.

Presentation of Riker Laboratories Company Representative

The President announced that the Riker Laboratories, Inc., were exhibiting at the meeting, and he called upon Mr. Alfred G. Colby to address the Association briefly. Mr. Colby expressed the appreciation of his company at being permitted to attend the meeting, and he invited the physicians to visit the technical exhibit at the conclusion of their meeting.

Citation to Rescue Squads

Dr. William J. O'Connell stated that the Executive Committee had voted to award citations to the two rescue companies of the Providence Fire Department for their outstanding community service in rendering emergency aid. Dr. O'Connell's remarks in connection with the presentation are made part of the official minutes of the meeting.

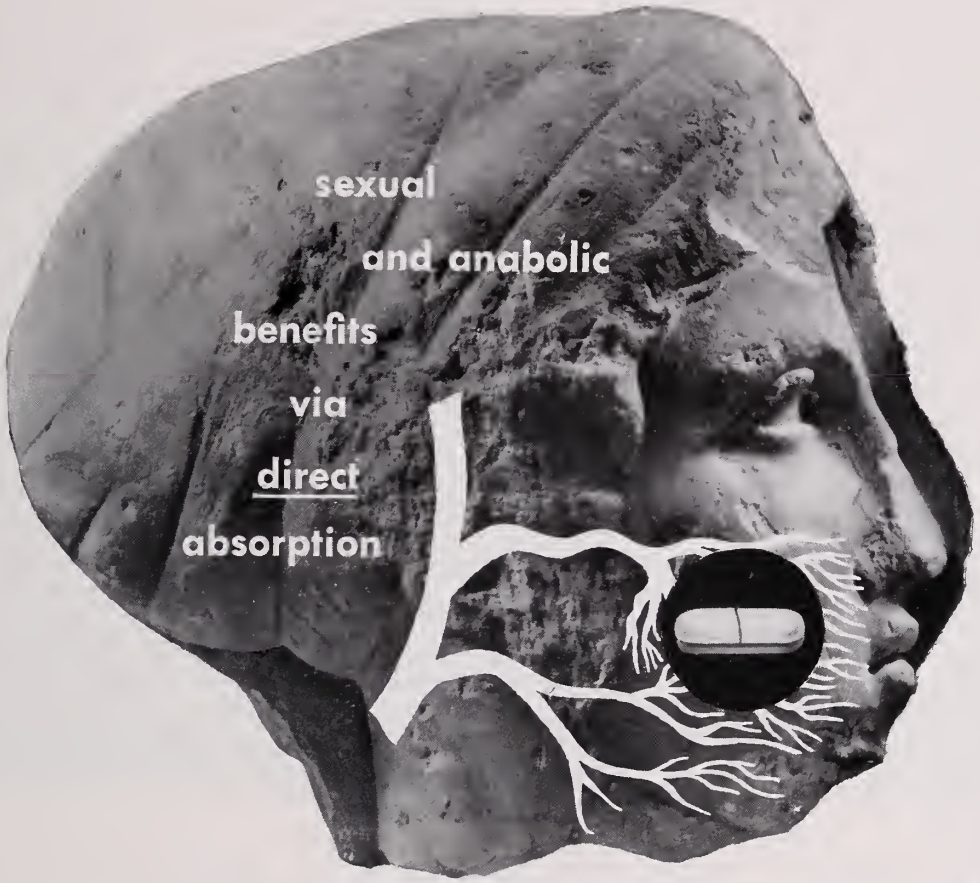
At the conclusion of his remarks he presented an engraved plaque to Captain Frederick L. Badger of Rescue Co. No. 1 and to Lieutenant Arthur Brodeur of Rescue Company No. 2.

Mr. Lewis A. Marshall, Chief of the Providence Fire Department, responded for the department and expressed the appreciation for the honor conferred upon the Rescue Companies by the physicians of Providence.

Scientific Program

Dr. O'Connell introduced as the guest speaker of the evening Dr. Derek Denny-Brown of Boston, Massachusetts; James Jackson Putnam, Professor of Neurology, Harvard Medical School, and Neurologist-in-Chief, Boston City Hospital, who spoke on "The Clinical Problem of Aseptic Meningitis."

concluded on page 104



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C I B A Summit, N.J.

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PROVIDENCE MEDICAL ASSOCIATION

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Dr. Denny-Brown gave an excellent talk on the problem of Aseptic Meningitis. His talk was supplemented by the use of beautiful plain and kodachrome lantern slides demonstrating examples of the various kinds of meningitis.

His talk was well received.

The meeting was adjourned at 10 p.m.

Attendance was 94.

Collation was served.

Respectfully submitted,
MICHAEL DIMAIO, M.D., *Secretary*

WASHINGTON COUNTY MEDICAL SOCIETY

The Washington County Medical Society held its first quarterly meeting of 1955 at the Haversham Inn, Westerly, Rhode Island, on January 12, 1955.

The following were elected to serve as officers of the Society for the ensuing year:

President—Sylvester A. Capalbo, M.D., Wakefield
1st Vice President—Hartford P. Gongaware, M.D., Westerly
2nd Vice President—Frederick C. Eckel, M.D., Westerly
Secretary-Treasurer—Martin J. O'Brien, M.D., Wickford
Councillor—Samuel Nathans, M.D., Westerly
Delegate—James A. McGrath, M.D., Wakefield
Alternate Delegate—Hartford P. Gongaware, M.D., Westerly
Auditor—Henry B. Potter, M.D., Wakefield
Censor—Freeman B. Agnelli, M.D., Westerly

Respectfully submitted:
MARTIN J. O'BRIEN, M.D., *Secretary-Treasurer*

PAWTUCKET MEDICAL ASSOCIATION

A regular monthly business meeting of the Pawtucket Medical Association was held November 18, 1954, in the library of the Pawtucket Memorial Hospital with fifteen members present. Dr. Harold A. Woodcome, President, called the meeting to order at 11:30 A.M.

The minutes of the October meeting were read and accepted.

The applications of Drs. B. Veit and Thomas J. Mathieu for Associate membership were read and referred to the Standing Committee.

Action on the application of Dr. Veit is to be postponed pending confirmation of active membership in the Newport County Medical Society.

The results of the poll of the active members regarding Social Security for doctors were read as follows:

Replies: 57 For: 37 Against: 18 Undecided: 2

Dr. Woodcome announced that Dr. William X. Pinault, Director of Public Health for the City of Pawtucket, was resigning his position in December to take further training in obstetrics. Dr. Pinault had requested from Dr. Woodcome an opinion as to whether the Association believed that this office, the Director of Public Health, should be held by a Doctor of Public Health or a Doctor of Medicine. Dr. James P. Healey stated that, in his opinion, an M.D. should be the Director, but that a specialist in the field of Public Health should be a member of his staff. After considerable discussion, Dr. Earl J. Mathewson moved that this question be referred to the Committee on Public Health, and that this Committee confer with Dr. Pinault and whatsoever other sources necessary to draw up a set of resolutions, representative of the opinion of the Pawtucket Medical Association and suitable for presentation to the Department of Public Health; this Committee is to report in ten days and is to be reimbursed for whatever expense may be incurred. The motion was seconded by Dr. Earl J. Mara and carried on a voice vote.

Dr. Woodcome stated that it is his intention to call a special meeting of the Association as soon as the Committee report is received in order that we may vote approval or disapproval of their findings and transmit our action to the proper authorities should they be approved.

The meeting adjourned at 12:04 P.M.

* * *

The dinner portion of the meeting was conducted at the Lindsey Tavern beginning at 6:30 P.M.

Following a very good dinner a panel discussion on "Drugs, Druggists and Doctors" was presented. The druggists were represented by Mr. Leo C. Clark, Jr., Mr. Arthur A. Forcier, and Mr. W. Pinault. The doctors were represented by Drs. Hrad H. Zolmian, Harry Hecker and Earl F. Kelly; moderator was Dr. Charles L. Farrell.

The discussion, in the form of questions and answers, was very interesting, informative and constructive, and all parted on good terms. As a result of this meeting, it has been decided that a liaison team will be appointed to iron out our differences during the year. It is hoped that we will be able to arrange a similar meeting once a year.

A total of fifty-three druggists and doctors were present.

Respectfully submitted:
PHILIP J. LAPPIN, M.D., *Secretary*

YOU ARE INVITED

The Community Workshops of Rhode Island, Inc., extends an invitation to interested physicians to attend its twenty-fifth anniversary meeting to be a Dutch treat luncheon-meeting at the Crown Hotel, Providence, from 12:00 to 2:00 P.M., on Tuesday, March 22. Main speaker will be Dr. Dean A. Clark, general director of the Massachusetts General Hospital.



Providence Journal-Bulletin Photo

PROVIDENCE MEDICAL OFFICERS

Left to right: Michael DiMaio, M.D., *Secretary;* Robert G. Murphy, M.D., *Treasurer;* Francis H. Chafee, M.D., *President;* William J. O'Connell, M.D. *Retiring President* receiving gavel award from Dr. Chafee; and Dr. Robert R. Baldridge, M.D., *Vice President.*

Relax the best way ... pause for Coke



Time out for refreshment

DRINK Coca-Cola REG. U.S. PAT. OFF.



MULTIPLE SCLEROSIS

concluded from page 88

quite widely in use at the present time.

Tubocurarine has been helpful in relieving bladder symptoms but must be given under supervision and carefully administered.

A new drug by Merck called MKO_2 has assisted in controlling spasticity, but it is too early for any conclusive reports to be published as yet.

A new drug which is just being used in multiple sclerosis is Isoniazed. This is being tried by the Veterans Administration and it will be some time before it is clinically evaluated.

Jones, who did considerable work in multiple sclerosis on the West Coast, recommended Euphased as the best anti-depressant sedative now available and it is useful in controlling the tremor in multiple sclerosis. In concluding his remarks regarding the pharmacological approach to multiple scelerosis the article stated, "there is no verified specific therapeutic agent as a cure in multiple sclerosis. The patients who are afflicted with multiple sclerosis require symptomatic and supportive treatment and such treatment frequently is of significant benefit."

In attempting to strike this note of optimism regarding multiple sclerosis, I would like to point out: 1) there is a new and healthy interest in multiple sclerosis; both in Rhode Island and nationally, and this interest is being manifest by leading research workers who are working in the field; 2) the National Organization has spent $743,000.00 on 45 completed problems on various aspects of the disease. The U. S. Government has 118 research projects under way, costing approximately $1,380,000.00, and they are being intensively pursued in various medical centers. Finally, I feel that the same spirit that has conquered diabetes, pernicious anemia, and the infectious diseases, and the same spirit which is working so patiently and persistently on polio and cancer will soon solve the riddle of multiple sclerosis and in this, as physicians, we can all take renewed courage and transmit that courage to our patients.

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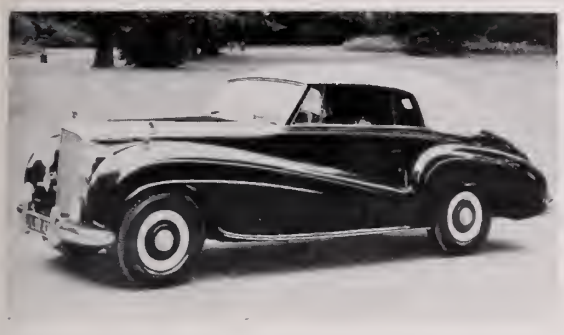
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Hillside Farms

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MILK COMMISSION REPORT — PROVIDENCE MEDICAL ASSOCIATION, 1954

Certified milk in Providence during 1954 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Hampshire Hills Farm, Wilton, N. H.; Hillside Farm, Cranston, R. I.

Through the courtesy and cooperation of the Boston Commission we have accepted their certification of one farm from Massachusetts and one from New Hampshire.

Bacteriological and chemical examinations of certified milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart.

All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella abortus infections.

This Commission, two years ago, discontinued the sale of Raw Certified Milk in the Providence market to conform with the standards in most of the larger cities. The legal standard for Pasteurized Certified milk is still 500 colonies per c.c. and the actual count on all samples examined by this Commission the past year was 102 colonies per c.c. The prepasteurized count on this milk must be under 10,000 and the actual count was 2414 colonies per c.c.

Vitamin D Certified Milk is defined as whole Certified Milk rendered antirachitic by irradiation or by the addition of a concentrate and shall be of sufficient vitamin potency to show, by biological assay, a content of at least 400 U. S. P. units per quart.

The Wisconsin Alumni Research Foundation of Madison, Wisconsin, is doing the assaying of Vitamin D from Hillside Farm and the results have been entirely satisfactory. Two tests per year are required by this Commission.

Certified Fat-free (Skim) Milk, containing not more than 0.05 per cent butter fat, and with Vitamin A added has conformed to the standards set by the American Association of Medical Milk Commissions.

One Milk Supply ran high counts, (Pasteurized), for several weeks due to a gram positive spore forming rod, obviously air-borne, which went through the pasteurizer without injury. The source of contamination must have been discovered at the plant, since the high count disappeared suddenly and has not returned. The second supply was due to gram positive rods, which have not as yet developed spores, although they have the typical appearance of spore forming rods. At present these are being investigated. These samples were from different farms.

The American Association of Medical Milk Commissions in their Methods and Standards for the Production of Certified Milk, require that each producer shall make or have made, once per month, a titration of Brucella agglutinins in the whey of the milk, whether the milk is raw or pasteurized. All titrations on the whey of the milk obtained from raw milk from Hillside Farm during the past year have been negative.

The Commission is indebted to Professor Stuart of Brown University for his continued cooperation in supervising our laboratory work at Brown University.

Frank I. Matteo, M.D., *Chairman*
D. William Bell, M.D.
George E. Bowles, M.D.
Bertram H. Buxton, Jr., M.D.
Harold G. Calder, M.D.
John P. Grady, M.D.
Henry E. Utter, M.D.
Reuben C. Bates, M.D., *Secretary*

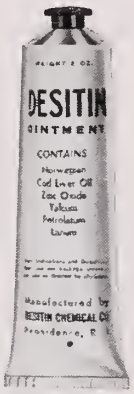
MONTHLY AVERAGES OF CERTIFIED MILK FOR 1954

	CHERRY HILL H. P. HOOD			HAMPSHIRE HILLS			HILLSIDE FARM								
	Pasteurized			Pasteurized			Pasteurized			Skimmed with Vit. A & D			Raw		
	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.
January	3.8	12.32	24	4.1	12.79	37	4.0	12.71	8	.1	8.32	30	4.0	12.70	2,900
February	3.8	12.18	19	4.1	12.58	93	4.1	12.47	4	.1	8.23	15	4.7	13.49	1,300
March	4.0	12.45	46	4.1	12.61	24	4.1	12.68	17	.3	8.37	15	3.7	11.94	1,800
April	4.0	12.43	7	4.1	12.65	149	4.1	12.67	9	.7	8.90	13	4.0	12.35	5,400
May	3.9	12.32	8	4.1	12.68	280	4.3	12.77	16	.6	8.75	22			
June	4.0	12.18	14	4.1	12.31	179	4.5	12.89	200	.2	8.22	300	5.3	13.66	4,220
July	4.1	12.42	12	4.0	12.36	646	4.0	12.20	151	.1	8.30	99			
August	4.0	12.16	21	4.1	12.45	304	4.0	12.28	61	.1	8.26	19			
September	4.0	12.20	15	4.1	12.55	577	4.4	12.75	46	.1	8.38	49	7.9	16.23	80
October	4.1	12.31	11	4.2	12.56	319	4.1	12.46	8	.1	8.31	14			
November	4.1	12.58	7	4.2	12.59	58	4.2	12.51	74	.1	8.45	46			
December	4.1	12.72	2	4.0	12.31	13	4.1	12.44	542	.1	8.28	236	4.4	12.68	1,200
Yearly Average	4.0	12.35	16	4.1	12.54	223	4.1	12.56	95	.2	8.39	72	5.0	13.29	2,414

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THE DOCTOR AND HIS INCOME TAX

continued from page 99

(4) *Small instruments.* A doctor would be permitted the full deduction in one year for the cost of purchasing small instruments which even though they may have a useful life of more than one year are required to be replaced oftener because of breakage or loss.

(5) *Cost of attending professional conventions.* The cost sustained by the doctor in attending professional conventions or meetings is fully deductible; such expenses would include meals, travel, lodging and entertainment while in attendance at the convention. I might add that the expenses of the doctor's wife who attends with her husband would not be allowable as a deduction; this would hold true even though the doctor's wife is a member and attends the convention of the Woman's Auxiliary which is being held at the same time and place, as it is held that the auxiliary is a social organization and does not in any way promote the profession of her husband.

(6) *Club dues.* This deduction is one that is usually rejected by the Revenue Service because of the taxpayer's inability to prove that the membership in such a club is essential to his business or profession, which holds true not only with respect to doctors, but also to many other classes of taxpayers. The taxpayer who claims a deduction of this type must be prepared to prove that the membership in the club is primarily for business purposes and not for his personal recreation.

(7) *Professional assistants' fees.* The doctor must furnish evidence that the fees were paid for actual services rendered by such assistants. The doctor who claims a deduction under this heading must maintain a record of the person and the amounts paid. A doctor who employs another doctor should not enter the wages paid in this category as they would be included under salaries and wages paid, line 12 of Schedule C.

(8) *Miscellaneous expense.* Under this heading there should be all expenditures which total less than $50.00. This is most expedient because of the lack of space in Schedule C-2 since the itemizing of all small expenditures would require additional detail and effort.

Estimated Tax

All doctors who are in private practice are required to file estimated tax returns for the current year and pay the tax so estimated in installments, if they so elect.

The 1954 code has extended the filing date of the estimated tax return, Form 1040, to April 15, of each current year (previous law required the returns to be filed by March 15).

There has been no change in the due date of the payments after the first installment is made. The taxpayer who files an estimated tax return on April 15, 1955, will be required to pay the subsequent installments on June 15, September 15 and January 15 of the subsequent year.

The new law also provides that a taxpayer who might be required to file an amended declaration of estimated tax for 1955, on January 15, 1956, would not be subject to any penalty for not filing the amended declaration if he filed his final income tax return, Form 1040, on or before January 31, 1956.

Conclusion

In these times of high taxes, it is most important that the taxpayer maintain adequate and proper records with which he may substantiate the figures reported on his return. I might add that once a return has been filed with the Internal Revenue Service the burden of proof with respect to the figures on the return is upon the taxpayer. In those cases where the Treasury alleges that a fraud has been committed the burden of proof in alleging fraud is upon the government. While discussing fraud, I wish to add that a tax avoidance is perfectly legal; avoidance of tax is defined as taking advantages of any legal loopholes, whereas tax evasion is illegal, for instance:

(1) Dr. John Williams has an offer to sell real estate which he has owned for three months at a profit of $15,000.00. If Dr. Williams sells the property at this time, he would be required to report $15,000.00 as ordinary income in his return for 1954, as if he had earned that amount in the practice of his profession. Dr. Williams, however, could for a substantial sum give the purchaser an option and postpone the actual transfer of the property until he had held it for more than six months, in which case Dr. Williams would be required to include in his return $7500.00 (one-half of the gain of $15,000.00) treating it as a long-term capital gain. The tax on this transaction could not in any case, exceed 25% of the full $15,000.00 gain or $3,750.00 if Dr. Williams is in the upper tax brackets. This would clearly represent tax avoidance on the part of Dr. Williams which would be perfectly legal.

(2) If Dr. Williams intentionally omitted the gain from his return, whether he sold the house before or after

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the six-month period, he could then be charged with fraud.

It is most important that the doctor maintain proper records, regardless of how simple the method he uses; the only requirement is that the examining agent will be able to determine from the records submitted that the income and expenditures have been properly reported.

Many times during my years of service I have had agents report back that not only doctors, but also other taxpayers present the agent with a bundle of cards containing the patients' medical record, the date and amounts of each payment made for the services rendered, and in addition, a couple of cardboard boxes containing all paid invoices, thus expecting the agent to do his bookkeeping. The maintaining of proper records in this respect would not only speed up the examination, but in many cases might result in a tax refund.

Since the advent of the medical expense deduction, many taxpayers are requested, when their returns are examined, to submit receipted bills for the expense claimed as having been paid during the year.

Many times, the taxpayer reports back that the doctor is unable to furnish him the exact dates and amount of the payments, which usually results in the doctor's return to be called for a field audit, as it is felt that his records are not properly maintained. Upon contact with the doctor it was disclosed in some cases that the patient did not approach the doctor, because he had not paid him for professional services during the year. I wish to add that since the advent of the medical expense deduction there has been abuse by some taxpayers of this tax reduction feature; the doctor should be prepared to furnish his patients with specific dates and amounts paid to him for all services rendered.

When the taxpayer's records are not in proper order the Commissioner is permitted to compute the tax by the use of any method that may properly reflect income. There follows two methods which may be used with respect to professional practitioners:

(1) Net Worth—Living Cost Method (to arrive at taxable income)

(2) Bank Deposits — Expenditure Method (to arrive at taxable gross income)

(1) *Net Worth—Living Cost Method*

Under this method, the agent will determine through the use of a balance sheet:

(a) the taxpayer's net worth at the beginning and end of the year in question, also he will total

(b) all expenditures during the year from living cost and other luxuries, such as purchase of a new

continued on next page

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automobile, vacation trip, purchase of family requirements, clothes, etc.

(1) Dr. Henry Warren's 1953 return was being examined and because of the agent's inability to determine the correctness of the return, as the doctor lacked sufficient records; the agent was forced to use the net worth method as follows:

Assets	*December 31, 1952*	*December 31, 1953*	*Increase or Decrease*	
Automobile	$ 3,000.00	$ 4,000.00	$1,000.00	
Real Estate	15,000.00	22,000.00	7,500.00	
Securities	20,000.00	15,000.00	(5,000.00)	
Jewelry	none	9,000.00	9,000.00	
Savings Bank	4,200.00	3,100.00	(1,100.00)	
		Increase		$11,400.00
Food, taxes, clothing, interest payments		$ 7,300.00		
College expense for daughter		2,000.00		
Vacation trip with wife		950.00		
Life insurance premiums		1,200.00		
Furnished to mother as dependent		950.00		
Total living expenses				$12,400.00
Total subject to inclusion in taxable income				$23,800.00

(2) *Bank Deposit—Expenditure Method.* This method would include all bank deposits, unless the taxpayer could show that some of the deposits were a return of capital to which is added all living expenses paid in cash during the year. An additional effort should be made to discover if there has been a duplication of deposits, as follows:

(1) Mr. Marcus Miller's income tax return for 1953 was being examined by an agent from the District Director's office, and it was disclosed that he operated a market and every Thursday he withdrew approximately $300.00 from his checking account to cash customers payroll checks. The examination revealed the following:

Bank deposits (savings)	$ 3,000.00	
Bank deposits (checking)	39,000.00	
Living Expenses	7,000.00	
Cash purchases (business)	21,000.00	
Total		$70,200.00
Less: Weekly withdrawals (52 x $300.00)		15,600.00
Balance—gross receipts		$55,600.00

The examiner would then be required to reduce the total gross receipts determined by this method the deductible business expenses including depreciation, if any, in order to arrive at the net profit.

The pleading of inexperienced bookkeeping or inability to keep books would not justify the elimination of the additional tax, if any. The fact that a doctor may plead lack of time to devote to keeping his records would have no bearing on the result determined. There have been many instances where hospital records have been resorted to when a doctor's records have been inadequate with respect to total receipts. The courts have decided in the favor of the government in this matter and declared the procedure legal in every respect. There have been cases on record where the agent has not only recorded the activities of the doctor under investigation, but also other practitioners whose hospital practice is extensive.

I wish at this time to pay my respects to my former colleagues, the internal revenue agents, who I know are technically trained, both by schooling and experience in successfully accomplishing their assigned duties. I also wish to correct a misunderstanding shared by many taxpayers, and that is that the agents are required to report additional taxes on each examination conducted. This is far from the truth; the agent is required to make an examination which must be impartial and fair, and usually where there is a question of doubt he gives the taxpayer the benefit of the doubt. In addition, there are many examinations where the agent, because of his digging in the taxpayer's records, discloses a large overpayment which may be recovered by filing a statement of overassessment. There are still those taxpayers who believe that revenue agents are paid on a commission; that is, on the basis of the additional tax they report.

A further proof of the efficiency of the revenue agents and the staff of the Director's office throughout the country is the following data concerning the returns filed by taxpayers during the fiscal year, 1952:

54,000,000 were accepted as filed
1,200,000 required minor adjustments
714,000 were settled at lower levels of Internal Revenue Service
35,000 were settled at intermediate level of Internal Revenue Service
9,400 required discussion at upper level of Internal Revenue Service
1,200 were settled by the Tax Court
636 were decided in the United States Courts of Law.

My concluding admonition to all taxpayers is "keep accurate and complete records of receipts and disbursements." In this way the return filed may be checked not only expediently but efficiently.

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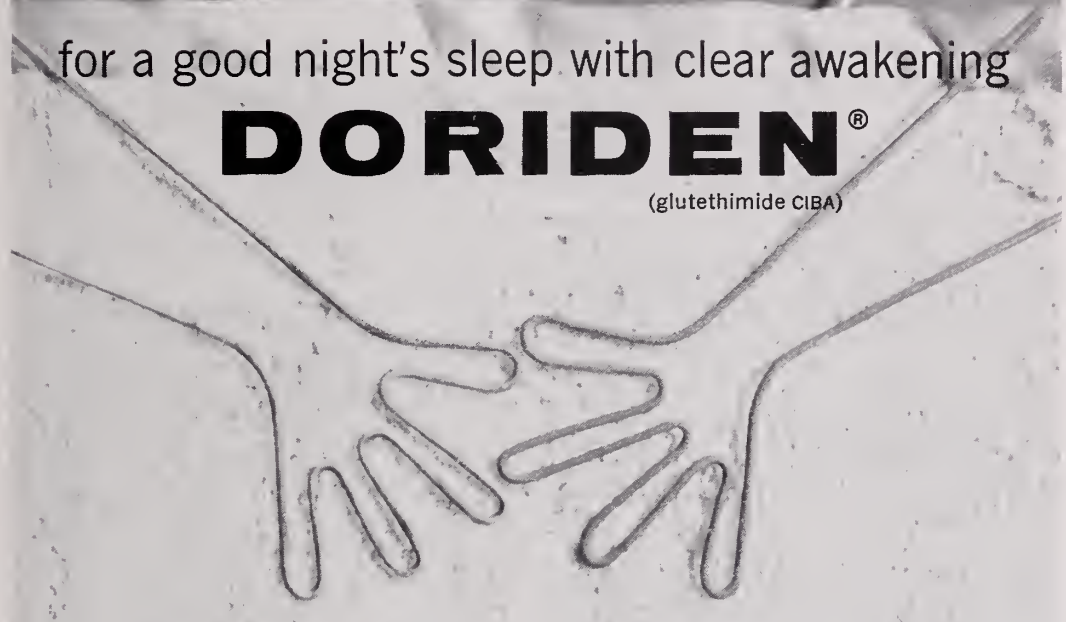
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RHODE ISLAND MEDICAL SOCIETY—NECROLOGY, 1954

REMINGTON PENDLETON CAPWELL, M.D., one of Providence's oldest practicing physicians, died on December 5, 1954.

Born in Phenix, Rhode Island, on January 5, 1872, Dr. Capwell attended elementary schools in Woonsocket. He received his Doctor of Medicine degree from Bellevue Hospital Medical College in 1894, and he was licensed to practice in Rhode Island in that same year.

Dr. Capwell was chief medical examiner for the Massachusetts Mutual Life Insurance Company for fifty years, and he also served as examiner for the Metropolitan, Manhattan and Mutual Life Insurance Companies. During World War I he was a captain in Medical Evacuation Unit No. 5, serving in France and Belgium.

Dr. Capwell was on the staff of the St. Joseph's Hospital. He held membership in the Chamber of Commerce, the Providence Medical Association, Rhode Island Medical Society, and the American Medical Association.

CHARLES WILLIAM DUNBAR, M.D., a practicing physician of Warren, died at his home in West Barrington on May 7, 1954.

Born in Providence on April 23, 1922, Dr. Dunbar attended elementary schools in Barrington and Barrington High School.

He received his premedical education at Brown University and he was a graduate of Yale University School of Medicine in 1946. He held a commission as Second Lieutenant in the Army Medical Corps and served in this capacity during the latter part of World War II.

Dr. Dunbar was an intern at the Providence Lying-In and Rhode Island Hospitals from 1946 to 1947. He was certified to practice medicine in Rhode Island in 1947.

Membership was held by Dr. Dunbar in the Bristol County Medical Society, Providence Medical Association, Rhode Island Medical Society, American Medical Association, National Association of Physicians and Surgeons, and he was a Diplomate of the National Board of Medical Examiners. He was also a member of St. Matthew's Episcopal Chapel, West Barrington, the What Cheer Lodge, F.&A.M. in Providence, and the Barrington Kiwanis Club.

LEROY K. HAGENOW, M.D., a Kent County practitioner, died on December 27, 1954.

Born in Hartford, Connecticut, on October 30, 1874, Dr. Hagenow received his preliminary education at Trinity College in Hartford. He graduated from Baltimore and Johns Hopkins Medical School in April 1898, and was licensed to practice medicine in Rhode Island in 1900.

Dr. Hagenow was elected to membership in the Rhode Island Medical Society in 1915. He was also a member of the Kent County Medical Society and the American Medical Association.

ALPHONSE J. LALONDE, M.D., a Blackstone Valley physician for more than fifty years, died February 5, 1954, in St. Petersburg, Florida.

Dr. Lalonde was born in Beauhornois, Quebec, Canada, and he was a graduate of the Bourget College in Rigaud, Canada, and Laval University in Montreal. He also studied at Harvard Medical School and trained for one year at the Mayo Clinic in Rochester, Minnesota.

He was associated with St. Theresa's Hospital, Woonsocket; St. Joseph's Hospital in Providence, and Notre Dame Hospital in Central Falls.

After his retirement four years ago, Dr. Lalonde moved to St. Petersburg, where he resided until the time of his death.

Dr. Lalonde was a member of the Pawtucket Medical Association, the Rhode Island Medical Society and the American Medical Association.

FRANK EDWARD McEVOY, M.D., who introduced a number of surgical techniques in Rhode Island, died on July 15, 1954.

Dr. McEvoy was born in Providence, on September 2, 1887, and he attended elementary and high schools there. After graduating as a Bachelor of Science from the University of Pennsylvania in 1910, he continued his medical training at the Medical School of the University, receiving his Doctor of Medicine degree in 1913. In that same year Dr. McEvoy was certified to practice medicine in Rhode Island; he also held licensure in Pennsylvania.

From 1913 to 1915 Dr. McEvoy served as an intern at the Episcopal Hospital in Philadelphia. He was first assistant surgeon at the Mayo Clinic

n Rochester, Minnesota, from 1915 to 1918, and was assistant in neurological surgery at the Clinic from 1918 to 1920. He then returned to Rhode Island and began his practice, specializing in general and neurological surgery.

For thirty years Dr. McEvoy was surgeon-in-chief at St. Joseph's Hospital, where he was also director of the tumor clinic. He was chief of thyroid and neurological surgery at Roger Williams General Hospital, and former chief of surgery at the Miriam Hospital and at the State Hospital for Mental Diseases. In addition, he acted as consultant at Charles V. Chapin, Rhode Island, Pawtucket Memorial, South County, Westerly and Notre Dame Hospitals.

A past president of the Providence Surgical Society, he was a member of the American Board of Surgery, a fellow of the American College of Surgeons, a fellow and Rhode Island regent of the International College of Surgeons.

Dr. McEvoy also held membership in the New England Surgical Society, the Providence Surgical Society, the Rhode Island Medical Society, the Providence Medical Association, the New England Cancer Society and the American Medical Association.

He was a member of the University Club.

WILLIAM HAILES PALMER, M.D., seventy-one, who had practiced medicine in Providence for forty-five years, died February 13, 1954.

He was born in Albany, New York on February 15, 1882, and he attended elementary schools and high school in Mechanicville, New York. Dr. Palmer was graduated from Cornell Medical School in 1903, and he served an internship at Bellevue Hospital in New York City. He was certified to practice medicine in Rhode Island in 1908.

Dr. Palmer was an assistant at Butler Hospital from 1905 to 1907. More recently he had been a consulting physician at the Rhode Island Hospital and adjunct surgeon at St. Joseph's Hospital until his retirement two years ago. Much of his work was in the industrial surgical and medical-legal field.

Membership was held by Dr. Palmer in the Providence Medical Association, Rhode Island Medical Society, American Medical Association, Alumni Society of Bellevue Hospital, New York, Sons of the American Revolution and the Thomas Smith Webb Lodge, F.&A.M.

JAMES FRANCIS RYAN, M.D., a practicing physician in Providence for nearly forty-four years, died January 28, 1954 at the age of seventy-two years.

A native of Providence, Dr. Ryan was born November 9, 1881. He attended elementary schools here and was a graduate of Classical High School. In 1909 he received his M.D. degree from the College of Physicians and Surgeons in Baltimore, Maryland, and he was certified to practice medicine in Rhode Island in 1910.

He served a one-year internship at St. Joseph's Hospital and was then appointed to that staff and also to the staffs of the Homeopathic and Notre Dame Hospitals. Dr. Ryan was formerly a physician for the Rhode Island Reds Hockey Club and the Narragansett Race Track. He frequently assisted the late Dr. Charles Perry on Block Island and also practiced there during 1950.

Membership was held by Dr. Ryan in the St. Paul's Council, Knights of Columbus; Hendricken Assembly, Fourth Degree of that order; the Providence Lodge of Elks, the Rhode Island Medical Society, the Providence Medical Association and the American Medical Association.

MICHAEL H. SCANLON, M.D., dean of Westerly physicians and former medical examiner and town councilman, died on January 21, 1954, after an extended illness.

Born in Middletown, Connecticut, on December 9, 1875, Dr. Scanlon attended Middletown High School, where he was elected to the All-Scholastic Connecticut football teams. He received his medical degree from the College of Physicians and Surgeons in Baltimore, Maryland, in 1899, and he served internships at the Backus Hospital in Norwich, Connecticut, and at the Fall River City Hospital. He was certified to practice medicine in Rhode Island and Connecticut in 1900 and then opened his Westerly office for the practice of medicine until his retirement in 1952.

He was a medical examiner in Washington County for twenty-six years. He was examiner for numerous life insurance companies in the Westerly area, a physician for the Westerly Police Department and for the New Haven Railroad. He also served a two-year term as a member of the Rhode Island Board of Charity and Corrections.

Dr. Scanlon was an original member of the staff of the Westerly Hospital and was a member of the hospital's advisory board. He served for several terms on the Board of Directors of the Westerly Visiting Nurse Association.

In public life, Dr. Scanlon served as a member of the Town Council, the Police Committee, Board of Highway Commissioners, and the Westerly Republican Town Committee.

During World War I he volunteered for service in the medical corps and was stationed at Fort Benjamin Harrison, in Indiana, with the rank of captain. In World War II, he was an examiner for the County Draft Board.

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NECROLOGY, 1954

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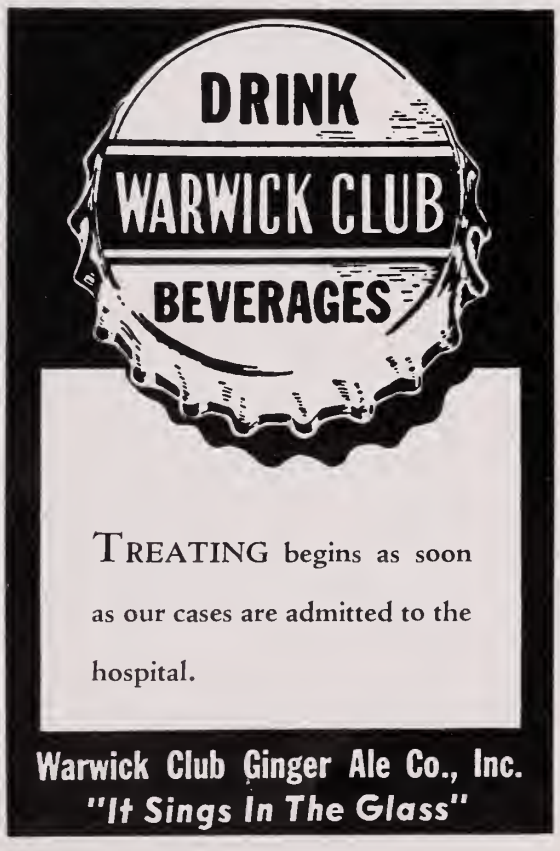
Dr. Scanlon's seventy-eighth birthday last December 9th was celebrated by a large group of patients, professional associates and members of the Westerly Graduate Nurses' Club, who honored him for his lifetime service to the people of South County.

He held memberships in the Washington County and Westerly Medical Societies and the American Medical Association; he was a past Vice President of the Rhode Island Medical Society.

BERTON W. STORRS, M.D., former health officer of Portsmouth, died on September 29, 1954, in Malone, New York.

A native of Morristown, New Jersey, Dr. Storrs was born on December 31, 1873.

In 1914 he was appointed health officer for the town of Portsmouth and he held that position until his retirement. He became a member of the Rhode Island Medical Society in 1904 and he was a member of the Newport County Medical Society and the American Medical Association. Dr. Storrs also held membership in the Eureka Lodge 22, A.F.& A.M., the Portsmouth Historical Society, and the Portsmouth Library Association.



BOOK REVIEWS

HUGH ROY CULLEN: A story of American opportunity by Ed Kilman and Theon Wright. Prentice-Hall, Inc., 1954. $4.00

The life of Hugh Roy Cullen, a Texas wildcatter who amassed a fabulous fortune through unerring judgment and uncanny luck, has become a contemporary legend in the Southwest and exemplifies the American way of life.

Leaving school at the age of twelve, Hugh Cullen went to work making one change after another until at the age of thirty he was a successful cotton man in Oklahoma. At this time he migrated to Texas with his family and after a brief sojourn in the field of real estate, he began his phenomenal career in Texas oil.

Outspoken in public affairs, philanthropic to the nth degree and a vigorous advocate of American freedom and democracy, Hugh Roy Cullen is best known for his gifts to medical and educational institutions, which total in the millions. This biography is a true-to-life adventure story which is easy and enjoyable reading.

SHIRLEY GARREAU

SURGICAL FORUM. Proceedings of the Forum Sessions, Thirty-ninth Clinical Congress of the American College of Surgeons, Chicago, Illinois, October, 1953. W. B. Saunders Co., Phil., 1954. $10.00

This compilation of all the papers presented at the Surgical Forum Session of the American College of Surgeons meeting held in Chicago in 1953, contains for the most part, the products of arduous research in the many and varied fundamental problems which remain unsolved in surgery today. Their source, in the main, is from the teaching centers throughout this country and Canada, from which emanate the policies and methodology followed by the majority of practicing American surgeons with reference to the more common surgical problems seen today.

Therefore, it would be expected that the framework of the majority of research presented is reasonable, and the conclusions drawn rational and honest. This is the case. It is to be assumed that from a number of these investigations will come further study which will bring ultimate answers to a good many of the current problems confronting surgeons every day. This seems particularly promising in the field of surgical shock, electrolyte imbalance and nutrition as well as in the area of cardiovascular physiology.

The book is divided into ten sections: 1. Heart and Great Vessels, 2. Blood Vessels and Circulation, 3. Lungs, 4. Esophagus, Stomach and Intestine, 5. Liver and Pancreas, 6. Burns and Renal Function, 7. Shock, Nutrition and Electrolytes, 8. Wounds, Infections and Antibiotics, and Anaesthesia, 9. Cancer and Steroids, and 10. Plasma Expanders.

Each section is introduced by a universally recognized authority in that particular field who summarizes in brief some of the more important contributions contained therein. For the most part, the majority of the contributions are the result of work done in the surgical research laboratory on experimental animals. However, there are a sizable number of papers in each section which are the direct result of carefully documented clinical observations.

The book is attractively bound and the format appealing. There is an appended bibliography and a good index. The material which has direct everyday usefulness to the practicing surgeon is to be found in the current surgical literature, nevertheless, this does not detract from the usefulness and value of the book which is judged to be almost indispensable to all surgeons who wish to keep abreast of modern surgical achievements.

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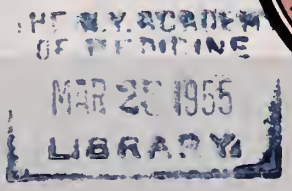
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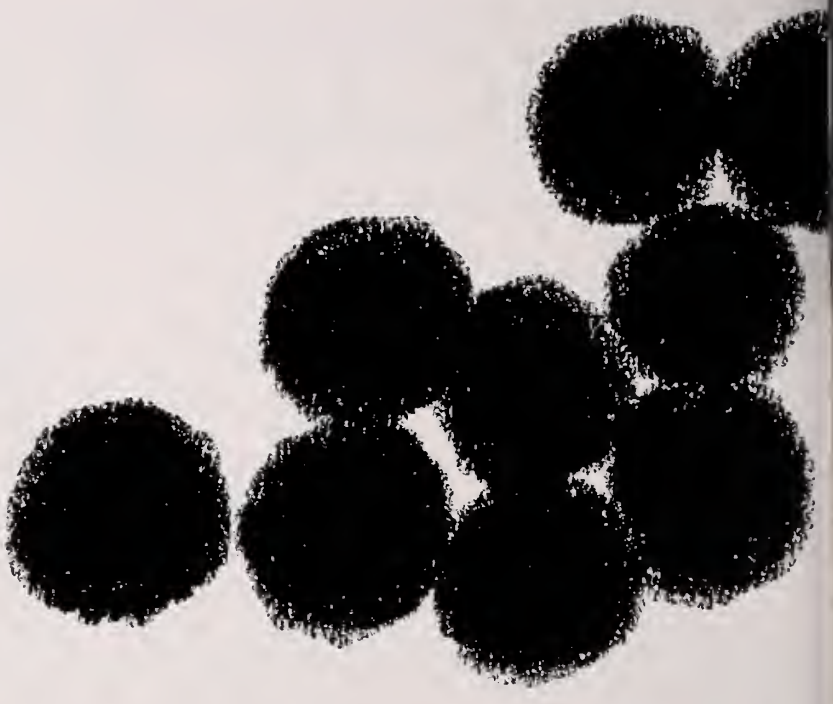
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*Pratt, R., & Dufrenoy, J.: Texas Rep. Biol. & Med. *12*:145, 1954.

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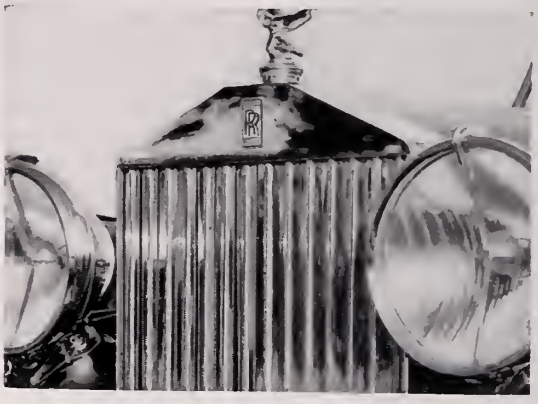
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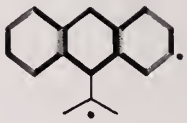
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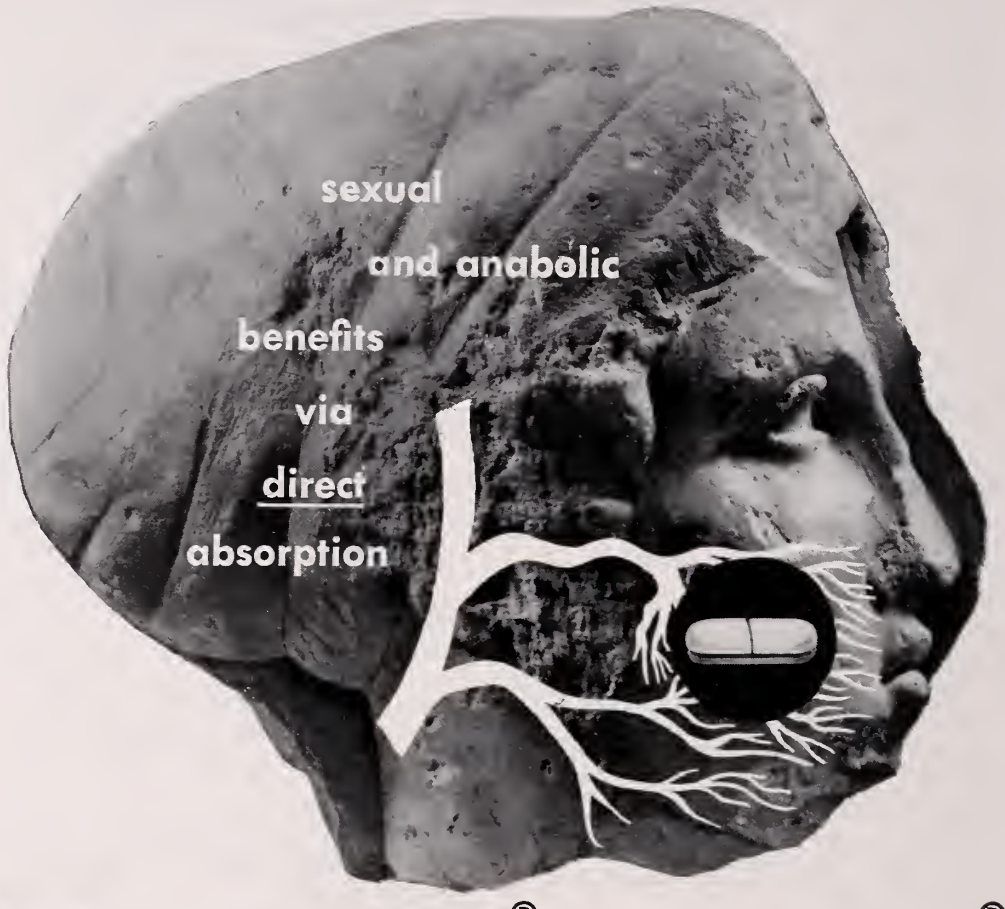
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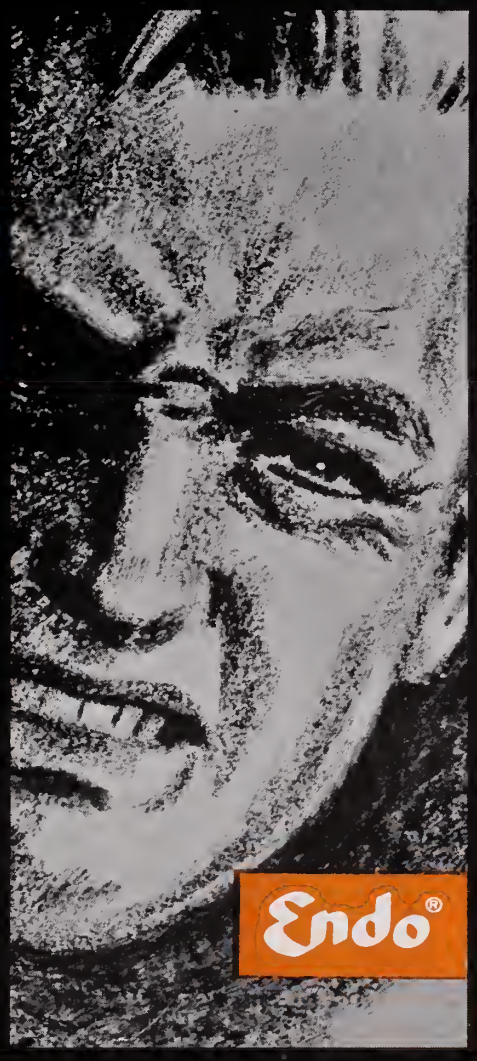
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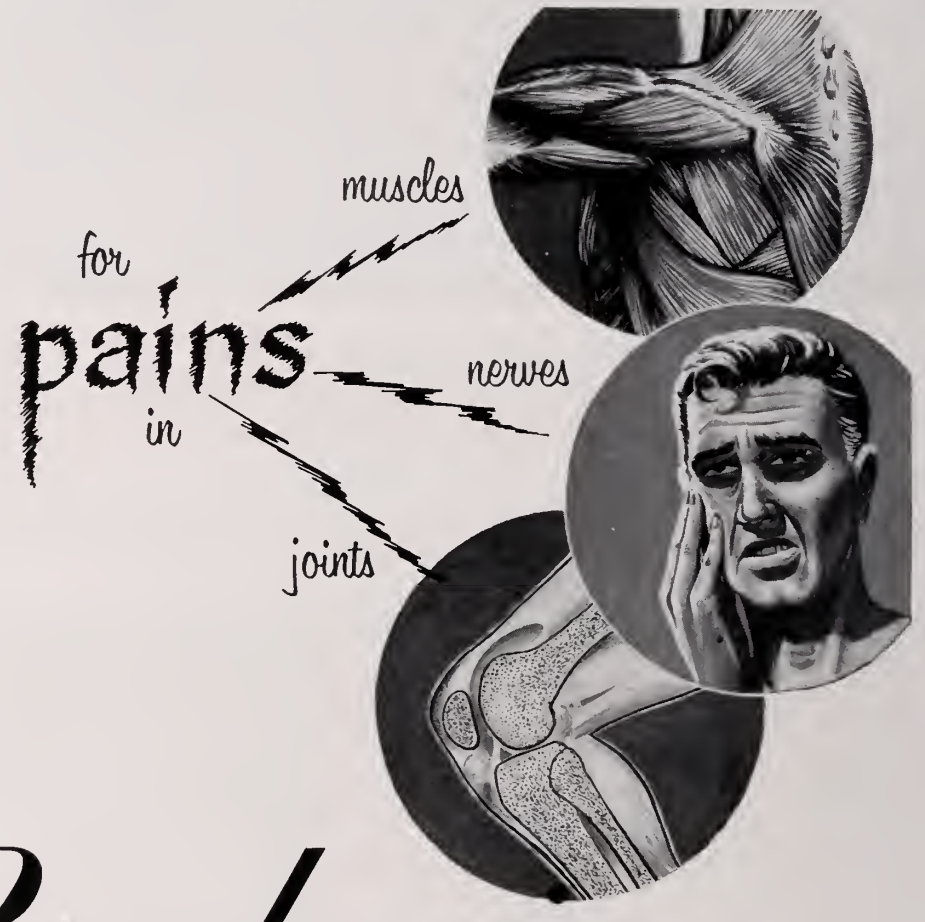
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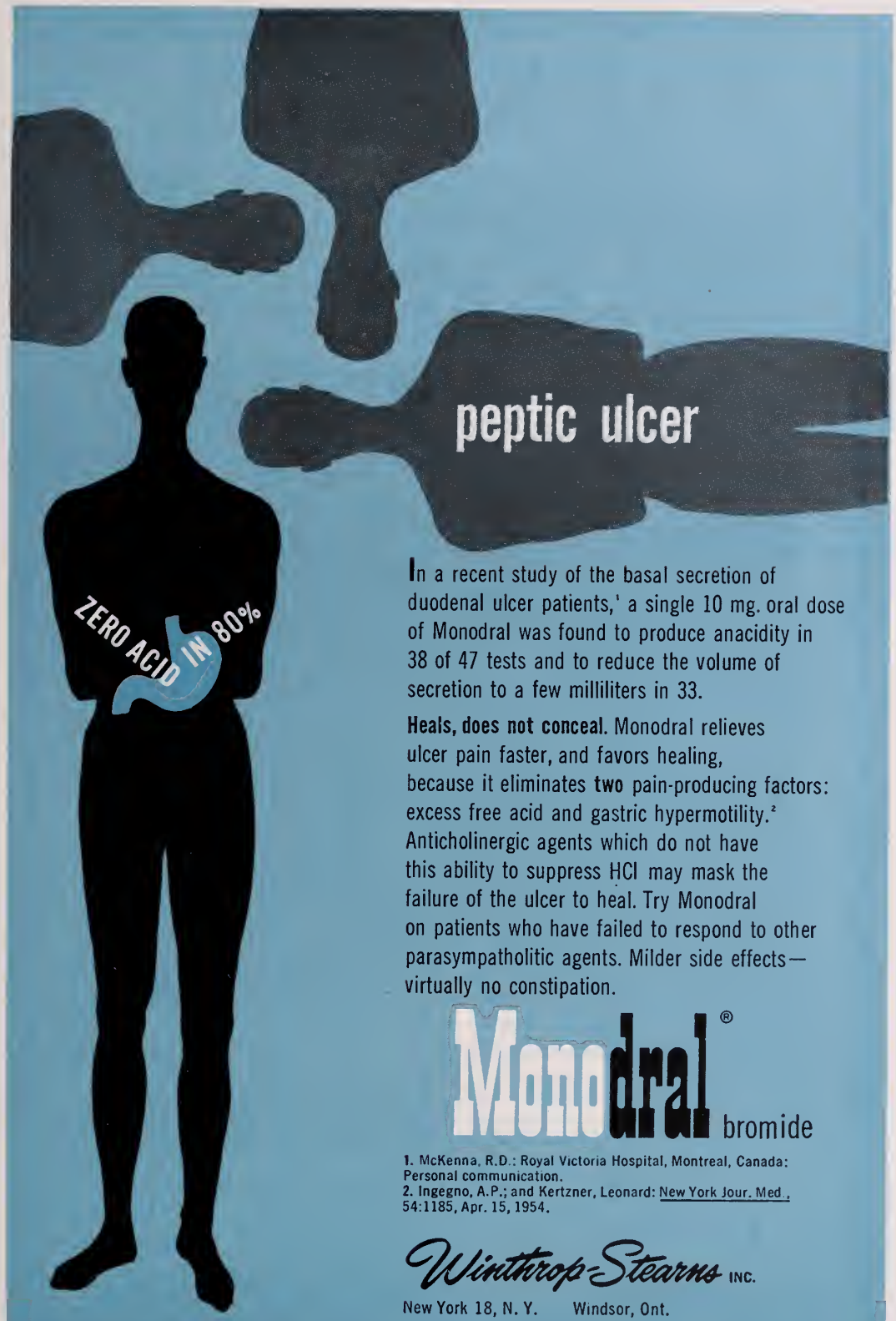


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1. McKenna, R.D.: Royal Victoria Hospital, Montreal, Canada: Personal communication.
2. Ingegno, A.P.; and Kertzner, Leonard: New York Jour. Med., 54:1185, Apr. 15, 1954.

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The RHODE ISLAND MEDICAL JOURNAL

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WHAT MAKES A GOOD HOSPITAL?

ALEX M. BURGESS, SR., M.D.

The Author, *Alex M. Burgess, Sr., M.D., of Providence, Rhode Island, Commissioner, Joint Commission on Accreditation of Hospitals.*

THE ANSWER to this question can be given in two words: "Good people." Otherwise stated, it is not bricks and mortar, not edifice nor equipment, not financial backing nor public support—though all of these are important—but *people*, people who have as the first requirement adequate skill and experience, and as the second—and even more important requirement—the right spirit and intentions. From the director, manager, superintendent, or whatever the top administrative officer may be called, down to the janitors and ward maids, the entire group of individuals who make up the hospital staff must be imbued with a spirit of cooperative endeavor in carrying out what they must all realize is the basic function of the institution—skillful and kindly patient care.

Given this spirit, it will follow that the best possible equipment that can be afforded will be obtained, the best organization that the group can devise will be put into effect, and the best possible educational programs will be developed. The primary product is good care of the sick; the excellent by-products are good training of physicians, nurses and other personnel, and valuable clinical research.

The whole subject of hospitals and hospital treatment has of late become of greater importance than ever before, because present-day diagnosis and treatment of disease requires the use of equipment and techniques that ordinarily cannot be utilized except in hospitals. As a result, hospital construction is going on at an ever-increasing rate. The only solution to the problem other than the construction of more and more hospitals is the development of home care programs, whereby convalescent and slightly ill patients can be transferred to their own homes for care and follow-up by hospital staff physicians and nurses, with temporary transfer to the hospital for special tests or treatments when necessary. This type of program is being put into operation by a number of hospitals at the present time, and will, of necessity, be further developed.

With this greater demand of hospital care, it is logical that more attention be paid to the maintenance of high standards in furnishing this care to the public. As everyone is aware, the American College of Surgeons has done a great public service in carrying out a country-wide program of examination and approval of hospitals since the end of World War I. This program was taken over on December 6, 1952, by the Joint Commission on Accreditation of Hospitals. This commission is made up of representatives of the American College of Surgeons, the American College of Physicians, the American Medical Association, the American Hospital Association, and the Canadian Medical Association. Under the supervision of the director, whose office is in Chicago, field representatives supported by the member organizations visit hospitals and attempt to determine in every instance whether or not the hospital under examination measures up to the standards adopted by the commission. The "Standards for Hospital Accreditation" adopted by the commission are those developed and used by the College of Surgeons with changes and additions which the commission has made. The field representative, who is a physician, has been carefully trained in his job, and his survey of a hospital is searching and painstaking, and enables him to determine with confidence whether or not the hospital meets the standards that have been set up, and therefore is in a position to offer to the people of its community the high quality of care which they should have. The activities of these field representatives are illustrated by the following, quoted from the BULLETIN which is published bimonthly by the Director of the Commission:

"In Car 5, Seat 22, a man adjusted himself for a long train ride. Two hundred miles and five hours later, he left the train. In another half-hour, he was talking to the administrator and the medical director of a 150-bed hospital. A member of the surveying team of the Joint Commission on Accreditation of Hospitals was at work.

continued on next page

"By train . . . plane . . . bus . . . automobile, the representatives of the three associations which carried out the survey program of the Commission in 1953 visited hospitals through the length and breadth of our lands. They are the eyes and ears of the Joint Commission. They look and they listen. They check facilities, confer with doctors and administrators, study procedures, do all the dozens of things which make the commission program possible.

"What does it mean to be a pair of eyes and a pair of ears (and a pair of legs) for the accreditation program?

"This is what it meant last year to one surveyor. He traveled 25,225 miles by train, plane and bus. He visited fifteen states and Canadian Provinces. He surveyed forty-seven hospitals with cancer facilities and thirty-six cancer clinics and diagnostic centers. He participated in ninety-five special conferences. He was away from his home base 244 of the 365 days of 1953.

"This is a typical segment of his year (between March 18 and May 4):

"He concentrated on Florida, Alabama and Mississippi. He visited the cities of Jacksonville (twice), Gainesville, Daytona Beach, Orlando, Ocala, Tampa, Lakeland, St. Petersburg, Kissimmee, Sarasota, Miami, West Palm Beach, Fort Lauderdale, Tallahassee, Pensacola, Montgomery, Birmingham and Columbus.

"He surveyed five hospitals and twenty-five cancer facilities and attended thirty conferences. During the year, this field representative had five such itineraries, sandwiching in two special itineraries as well."

It is not my purpose to describe to you the organization of the commission nor to go into the details of the standards that it has set up. I shall, however, attempt to give you a general view of what has been accomplished and then to discuss with you certain of the standards—those which are of especial concern to the medical staff of a hospital. In the first year of its operation—the year 1953—the commission surveyed 1,306 hospitals. Of these 949 were accorded full accreditation, 204 provisional accreditation, and 141 no accreditation. It is the intention of the commission to recheck every hospital once in three years. Those which have previously received accreditation from the American College of Surgeons will retain their status until revisited by a representative of the Joint Commission.

Every month each commissioner receives the report of the work of the field representatives for the previous month, with the final decision of the director as to the accreditation or non-accreditation of every hospital visited. Confirmation of these results by mail from the commissioners makes them official. In addition, each commissioner receives the list of hospitals in which the decision has been for either provisional or no accreditation with, in every instance, the deficiencies noted on which the unfavorable judgment is based. It would, perhaps, be of interest to examine the record of some of these deficiencies. They are shown in the accompanying tables, which are copied more-or-less at random from one of the recent reports of the director.

In most of these hospitals, it will be noted, the deficiencies for which criticism is made relate to staff organization and activities. In one, it is the presence of fire hazards; in another, the correction of fire hazards, and evidence of enthusiasm and ambition has resulted in the upgrading of the hospital to full accreditation. It is for others who are better qualified to speak of fire hazards, architectural defects and ineffective administration. These are important considerations and are not overlooked in hospital evaluations. For the purposes of this discussion, however, consideration will be limited to the activities of the staff, for it is almost always on the quality of these activities that the final judgment as to accreditation of the hospital depends.

TABLE I

ACCREDITATION STATUS OF HOSPITALS SURVEYED IN 1953

TOTAL	Fully Accredited	Provisionally Accredited	Not Accredited	Action Deferred
1295	949	204	141	1

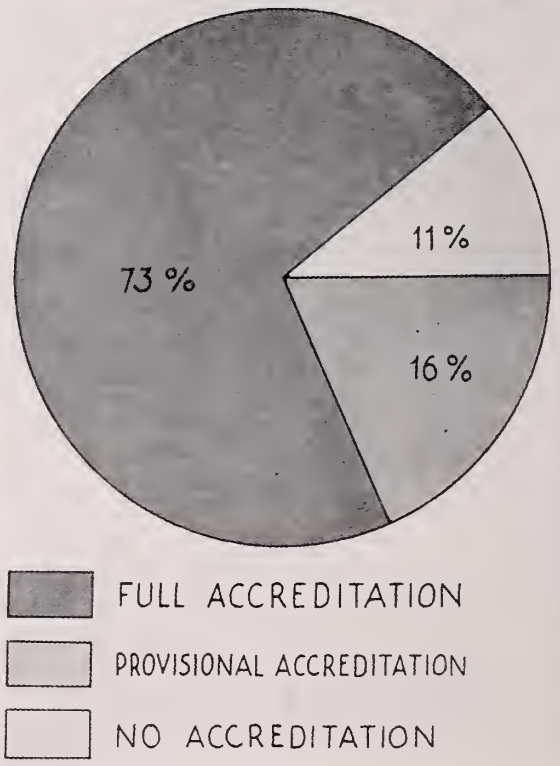


TABLE II

JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

660 Rush Street Chicago 11, Illinois

Hospital Reports Received and Scored
June 1, 1954 — July 10, 1954

The following is a list arranged alphabetically by State of hospitals which were granted:

Provisional Accreditation, No Accreditation, Or The Surveyor's Rating Has Been Changed By The Director

---

STATE

City *Name of Hospital (xx beds) PA[1]-FA[2]-NA[3]*

30% Penalty Deduction:

1. Lack of review of clinical work done in the hospital.
2. Poor attendance at staff meetings.
3. Medical record deficiencies.
4. Lack of recorded consultations, particularly in sterilizations.
5. No improvement in hospital since survey of 1951.

(1)=Previous rating PA=Provisional accreditation
(2)=Surveyor's rating FA=Full accreditation
(3)=Director's rating NA=No accreditation

Before launching into a discussion which is limited to the work of the staff, I would like to mention a very important factor which is indispensable in the creation of the smoothly working, efficient organization which our hospital should be. This is the factor of cooperation between the staff, the administration and the trustees. This, experience has shown, is best achieved by the formation of a Joint Conference Committee, as it is usually called, on which these three groups are represented. Such a committee is a *must* and is specified in the standards as required in all hospitals. Where the administrator is not a physician, and in view of the fact that the trustees or governing board (or whatever may be the name of the body that is legally responsible for the operation of the hospital) is usually made up of laymen, it is especially necessary; for it is difficult for a person who is not a physician to appreciate the qualifications and experience needed in the various specialties, the facilities and equipment that is essential and the relative importance of each specialty in the over-all picture. In the same way, it is difficult for the staff physician to appreciate the problems of the administration and trustees, the necessity for careful conservation of resources, the all-important factor of public relations, etc.

Regardless, however, of whether or not the financial support of a hospital is adequate, the standards of staff organization are applicable, as for the most part they cost nothing. This is illustrated by the following quotation from an article reprinted in the little journal TRUSTEE from the May 1954 issue of HOSPITAL PROGRESS—official journal of the Catholic Hospital Association:

TABLE III

City *Name of Hospital (xx beds) PA-FA-NA*

10% Penalty Deduction:

1. Obsolete by-laws, rules and regulations.
2. Inadequate staff organization.
3. Lack of recorded evidence of a thorough review of the clinical work done in the hospital.

City *Name of Hospital (xx beds) NA-PA-PA*

25% Penalty Deduction:

1. Fire hazards.

City *Name of Hospital (xx beds) NA-PA-PA*

10% Penalty Deduction:

1. Inadequate and obsolete by-laws.
2. Poor review of the clinical work.
3. Caesarean section rate of 11.3%.
4. Written consultations absent in many deserving cases.

City *Name of Hospital (xx beds) FA-PA-PA*

Previous fire hazards minimized, and approval from local Fire Department received.

There has been considerable improvement since survey of 1953, and the hospital as a whole is enthusiastic and ambitious. Warrants FULL ACCREDITATION with request of reports of continuous improvement.

"The most important criteria do not involve the spending of money, but rather the control of human conduct. The keeping of meaningful records does not involve any considerable outlay of capital. The work of a tissue committee presents no budget problem. Careful consultation and limitation of privileges do not call for plant expansion, but rather the intelligent and responsible use of scientific talents available. All of these are possible in any hospital—they cost no money, but they are most important as tools to improve the quality of hospital and medical care. In like manner, the establishment of a joint conference committee is easy to attain, and it can be most useful in clarifying the joint responsibility of the administration and the medical staff for good patient care."

Let us then consider the various activities of the medical staff that are essential to the conduct of a good hospital, any hospital—in fact, *every* hospital. Recognizing that in the care of the individual patient the all-important factor is the skill and faithfulness to duty of the individual physician who is in charge, there are also actions which should be taken by the whole group, the active medical staff of the hospital, by which excellent individual care can be made more effective and improvement of the whole professional environment can be brought about. The active staff is responsible for the "quality of medical care" and "the ethical standards of practice in the hospital." Besides the character and ability of the individuals who make up the staff, their organization for self-discipline and a constant check on their own work is an indispensable factor

continued on next page

in maintaining these essentials. Furthermore, it is they and they only who are qualified to pass judgment on the professional ability of applicants for staff membership and to make recommendations as to the privileges and duties that should be assigned to their own members. Meetings, conferences and records which require the earnest efforts of all concerned are involved.

The active staffs of all hospitals which admit patients suffering from acute medical and surgical conditions, be they large or small, should, and according to the "Required" standards, *must* have responsible officers, adequate bylaws conforming to the requirements of the Joint Commission, and the following committees:

Executive Committee
Credentials Committee
Joint Conference Committee
Medical Records Committee
Tissue Committee

Staff meetings are essential in the interest of improvement in patient care. The requirement is specific—one meeting a month and seventy-five per cent of the active staff in attendance. In larger hospitals where the staff is divided into a number of services, these meetings may be held by the individual services, so long as a meeting of the whole staff is held every quarter. Of course, accurate attendance records must be kept, and each individual staff member must maintain an average of attendance at seventy-five per cent of the meetings, unless excused because of illness, or absence from the community, or for some similar reason. This requirement may seem too severe, but let me assure you that where the essential spirit and enthusiasm are present, proper attendance is automatic.

The function of the committees and the necessity for their existence is, I believe, clear to all. The Executive Committee, as its name implies, is empowered to act for the staff, as directed by the staff, and to carry out routine duties of coordination of the various services, receipt of reports and suggestion to the staff of new projects and developments as may require the action of the staff as a whole.

The Credentials Committee is one of great importance in which every specialty should be represented. It has the grave responsibility of passing judgment on the qualifications of those colleagues who seek appointment to the staff, as well as on all staff members in the matter of the limitation of the privileges to be accorded them in the treatment of patients. These are matters of self-discipline that must be decided carefully and conscientiously, as there is nothing more fatal to the work and reputation of a hospital and, I may add, to the patients treated therein, than the admission of incompetents to hospital staffs, and giving them a free rein in the matter of operative work and other types of patient care.

The Joint Conference Committee has already been mentioned, and the value of its work in maintaining cooperation and understanding between the medical group and the Trustees and administration has been stressed.

The value of the committees thus far mentioned is generally well understood. This, however, is not always true of the Medical Records Committee. Physicians are at times inclined to forget the prime importance to the patient, to the hospital, and to himself of a medical record that is adequate and complete. The realization of this importance is very likely to be brought home to them sooner or later—sometimes with something of a jolt—in a court of law. Not only, however, in legal matters, but also in the continued treatment of patients, or in their re-admission to the hospital, are good medical records a necessity. Again, the physician who wishes to make a case report, a clinical study or a teaching demonstration must have an accurate record from which to work. We all know these things, and yet there is no phase of our activities which in our daily hurry we are more prone to neglect. It is hard to exaggerate the importance of that group of our colleagues, whom we designate as members of this committee, whose duty it is to make us toe the mark. The Tissue Committee, acting as a constant check on the accuracy of surgical diagnosis in instances in which tissue is removed, is again an important means of self-discipline and instruction, designed to bring about a steady increase in the quality of the work of the surgical staff.

These are the committees that are required of all hospitals. In most of the larger institutions it is advisable to create others for special purposes as the need arises. Of these, perhaps the most important is the Education Committee, which has supervision of the educational program of the hospital. This committee arranges meetings, invites guest speakers, and in general has the responsibility of seeing that the members of the staff not only have an opportunity to be kept up to date by the process of educating each other, but also benefit by the opportunity to listen to speakers of wide reputation who come as invited guests. Some hospitals employ a full-time physician of wide experience and many contacts with the profession as educational director to correlate and supervise this function. When there are interns and residents, such an officer is especially important in planning and carrying on their training. A special committee to deal with the selection of interns and their education may be appropriate. Another committee of importance is the Research Committee, whose duty it is to approve and encourage all research projects from simple case reports to the most elaborate investigations. Even in small hospitals where the opportunities for re-

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RECENT ADVANCES IN THE MANAGEMENT OF SEVERE AND EXTENSIVE BURNS

BERT S. JEREMIAH, M.D.

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SINCE the Second World War, many changes and much progress has been made in the treatment of burns. The major conflagrations that frequently occur result in large numbers of thermal injuries, and even now severe thermal catastrophes are anticipated in the future with the greater use of atomic energy. For these reasons, new and better methods are constantly being formulated to better cope with the atomic bomb victims, which may be in the thousands within a single city of the United States. In the past ten years, the mortality of severely burned patients has diminished considerably due to improved methods of skin grafting, early operations and better medical treatment.

At present in the United States, we have yearly approximately nine thousand deaths from burns of all types. We are striving constantly to reduce this high mortality rate by proper management of the patient with severe and extensive burns. It has been estimated that during peace time eighty-three per cent of all burns occur in the home, ten per cent in industry and seven per cent in public accidents. Careful medical supervision is essential in attempting to maintain normal physiochemical levels. The plastic surgeon is frequently called upon to handle a burned patient from the very beginning on the basis that eventually the reparative work will have to be done by him.

In the treatment of a severely burned patient, it is important to note that the systemic changes are of greater importance than the local therapy. If a patient is seen at the scene of the injury, a quarter or a half of a grain of morphine sulfate is given and the patient is immediately hospitalized. At the hospital, additional morphine may have to be given in order to control the severe and excruciating pain. Tetanus antitoxin and gas gangrene serum are given in some cases. We are also accustomed to giving twenty-five milligrams of ACTH which helps to prevent shock, reduces the intensity of pain and gives the patient a state of euphoria. In addition, six hundred thousand units of penicillin is given intramuscularly and repeated every twelve hours. The use of tannic acid and gentian violet has been discontinued in the better and more progressive hospitals and clinics, chiefly because of the suppuration hidden beneath the well-formed coagulum. Pyruvic acid has been abandoned also because of the excruciating pain that it so often produces.

The closed pressure method of treating burns was used extensively on the victims of the Cocoanut Grove disaster at the Massachusetts General Hospital a few years ago. More recently, the local use of the sulfonamides, either in powder or in ointment form, was widely used during World War II, but has now been abandoned because of the renal complications and many other systemic reactions which apparently resulted from unpredictable absorption.

Today, the most commonly used materials for the immediate local covering of the burned area are autoclaved gauze or rayon strips impregnated with furacin or vaseline. On infected or potentially infected areas, isotonic saline wet dressings are used either directly over the dressing or through fenestrated catheters. The preparations enumerated are not ideal, but are superior to the hundreds of proprietary ointments and other products that are on the market today.

If there is evidence of infection, we use wet dressings consisting principally of isotonic saline with two hundred fifty units of penicillin per c.c.



Fig. 1. Closed pressure dressing with multiple fenestrated catheters and Reynolds aluminum foil beneath ace bandage.

continued on next page



Fig. 2. Third degree burn of the entire foot treated with Tryptar and grafted thirteen days after the initial injury.



Fig. 3. Split graft applied on dorsum of foot. Note few sutures and fenestrations of graft to prevent accumulation of serum or hematoma.

of saline. The dressing is maintained moist through fenestrated catheters spaced at various intervals of a burned area. If pyocyanea has been demonstrated by cultures, we alternate with one-fourth per cent acetic acid in normal saline solution.

There is considerable time consumed with each dressing. Heavy sedation of the patient is preferable with each dressing and avoidance of repeated general anesthesia as it increases shock and diminishes resistance to infection. We have used intravenous surital to the point of analgesia during secondary dressings and even for grafting where no suturing of the grafts was indicated.

The care of even one severely burned patient is too much for the average physician or surgeon unless he has adequate experienced help to aid him. All the dressings should be done in the operating room under aseptic conditions with the patient sufficiently sedated. After the dressing is removed, cultures are taken to determine the predominant microorganism present. Any loose debris or slough is removed. No attempt is made in the initial dressing to remove dirt particles either by debridement or rubbing and scrubbing of the involved area. A gentle saline wash may be harmless but rubbing vigorously to remove imbedded and firmly adherent dirt particles will cause considerable disturbance of the existing epithelium. This will also greatly increase the depth and extent of the burn.

In applying the dressing, all the layers of the dressing including the impregnated furacin gauze are placed in a longitudinal manner except that of the outer layer which consists of the stockinettes or elastic bandages. If we wish to retain our solution within the dressing and prevent it from saturating through to the outside elastic bandage, we employ Reynolds heavy duty aluminum foil. This gives a continuous wet dressing that is often desirable during the warm months or when the humidity is high. The success of the wet dressing, either in the ungrafted or grafted case, depends on keeping it constantly and thoroughly saturated with the solution employed. An inadequate amount of the solution may defeat the entire purpose of the dressing. Excessive quantities of the solution employed (isotonic saline with penicillin) do no harm in our experience. The amount of the solution required will vary greatly. This will depend and vary with the temperature or humidity of the environment where the patient is confined. We have used as much as four ounces of the solution injected into each catheter every two hours, day and night. On the order sheet, it is very important to impress all the attending nursing personnel that the dressing be kept constantly and thoroughly saturated with fluid and that no harm can come from any surplus amounts.

We have frequently used tryptar to speed up demarcation and debridement of the third degree burns. The application of tryptar may be tried after the first dressing. A few days later, demarcation will be completed and the slough can be removed either by the Ferris-Smith blade or by means of the Padgett's electric dermatone. Either immediately or a few days later, the area may be skin grafted depending on the presence or absence of infection.

For the preservation of function; position is most important, particularly, of the hands and feet. The knee and elbow joints should be dressed in the extended position and the feet should be protected to avoid foot drop. Elevation of the upper and lower extremities is essential particularly during the healing period so as to encourage lymphatic drainage. Deep burns of the dorsum of the hands must be grafted very early, within a week if possible. If not, necrosis will develop, joints will be exposed and there will also be tendon fixation with fibrosis and

continued on next page



Fig. 4. Third degree burns of both hands with marked scar formation.



Fig. 5. Complete excision of superficial and deep scar followed by application of heavy split graft; one year postoperatively.



Fig. 6. Circumferential third degree burns of the lower extremities and trunk including buttocks and external genitalia.



Fig. 7. Same case as Figure 6, following multiple skin grafts.

deep scarring. Debridement particularly on the hands may be hastened by removing the necrotic tissue and skin grafting immediately. Sheets of skin grafts are used on the dorsum of the hands which extend to the midlateral lines of the fingers.

If considerable infection is present during the debridement, wet dressings or impregnated furacin autoclaved gauze may be used to prepare the recipient area. The specific antibiotic must also be used as indicated by cultures. Other helpful adjuncts that must be included are whole blood, plasma, high protein diet, vitamins and above all sympathetic encouragement to help the morale of the depressed and severely burned patient.

Blood transfusions must be given freely. One must not wait until the patient becomes anemic. Anemia develops very rapidly and is the result of destruction of the red blood cells at the burned areas, and also due to loss of blood during and with each dressing which sometimes has to be done every day.

The use of plasma as an initial replacement of fluids in severe thermal burns is not as efficacious as whole blood transfusions. In extensive third degree burns, we have given from one to two liters during the first twelve hours. This amount is regulated by the degree of shock present. Plasma is lost because of the increased capillary permeability. The simplest method to determine the amount of plasma needed in an acute burn case is to give one hundred c.c. of plasma for every point the hematocrit is above normal. If the patient is conscious, he is encouraged to drink large quantities of bicarbonate saline solution. The evaluation of the patient's condition is on the basis of temperature, pulse, blood pressure, urinary volume, specific gravity, red blood count, hemoglobin and the hematocrit. If the hematocrit is fifty or above, the patient's condition appears grave, blood transfusions should be continued until there is evidence of subsidence of shock. When shock is well under control, blood is given in five hundred c.c. amounts daily or every



Fig. 8. Circumferential healthy granulation tissue of upper extremity; ready for skin grafting.



Fig. 10. Third degree burn involving entire abdomen, perineal region, both thighs and right upper extremity of a seventy-three year old woman; treated locally with furacin autoclaved gauze.



Fig. 9. Same extremity as Figure 8, following skin grafting; two months postoperatively.



Fig. 11. Application of large sheets of pie-cut grafts. Fixation accomplished with topical thrombin and plasma.

two days in an effort to prevent anemia. Do not allow anemia to develop. It is a dangerous sign in a severely burned patient.

If acute renal insufficiency occurs, conservative methods should be used in the treatment; limit the fluid intake to urinary output plus adequate allowance for insensible water loss. To combat negative nitrogen balance in the extremely burned patient, one must administer proteins in amounts far in excess of normal individual requirements in addition to the multiple transfusions of the whole blood which may be indicated.

The use of homographs has greatly helped the extensively burned patient. It is very important to convert the necrotic wound into a closed wound. Homographs are used when not enough of the patient's own skin is available. In these cases homographs must be employed. The maximum survival time has been reported by some authors to be eight weeks. The use of cortisone and ACTH in our experience has not helped to promote and stimulate permanent survival. We have observed in the cases treated by us, that if the homographs used are of the same blood grouping as the patient, the survival period is much longer. We have no explanation to offer for this but the problem of homographs is now under intensive consideration and investigation.

The usefulness of ACTH and cortisone is controversial in the treatment of extensive burns. Some believe that ACTH is an indispensable drug in the treatment of severe burns. We do not believe this to be so. The only important changes we have noted when ACTH was used is slight diminution of pain and a mild state of euphoria. ACTH does not have any stimulatory effect on spontaneous epithelialization as was previously believed. We have not seen a higher percentage of grafts take because of the use of ACTH or cortisone. The degree of high take in a grafted area is determined by many other factors such as healthy granulation, absence of infection, immobilization of the areas grafted, prevention of hematoma which may undermine the grafts, and the use of antibiotics.



Fig. 12. Note excellent take of grafts with minimal scarring.

To combat infection, one must employ the most rigid sterile precautions in the initial and all of the subsequent dressings. Frequent cultures should be taken and appropriate antibiotics should be used. Wet dressings should not be overlooked whenever they are needed.

Our primary aim in the severely burned patient is early and complete coverage of the granulating surfaces so as to prevent loss of electrolytes, proteins and to avoid scarring and severe contractures. In severe burn cases, cosmetic considerations are entirely unimportant and are sacrificed. These are later or delayed problems and are undertaken after complete coverage and healing has taken place. The grafts may be cut with a dermatone and as thin as possible since thin grafts have a better chance for survival. If the donor area is limited as in cases where fifty per cent or more of the body is burned, the same donor area may be used two or three times at intervals of four to six weeks. We had a case which sustained seventy-five per cent third degree burns of the body, this included both lower extremities, external genitalia, buttocks, abdomen, chest up to the nipple line anteriorly, and to the level of the inferior border of the scapula posteriorly. The only available donor areas to be used were both upper extremities and upper third of the chest and back. These areas were used on four successive occasions with good results.

Recently, an acute revival of an old method has been employed, namely the open or exposed method of treatment. This method is based on common knowledge that bacteria are subject to various external influences in their growth. Such external influences have proved to be moisture, atmosphere, temperature, light and even chemicals. It is an established fact that room temperature is less favorable to the growth of bacteria than body temperature. It has also been found that certain factors are unfavorable to the growth and multiplication of pathogenic bacteria. These factors are exposure to light, lack of moisture and a temperature below that of the body. Upon these factors the exposed method of treatment is based. This method should

continued on next page



Fig. 13. Second and third degree burns of the entire face using the exposed method.



Fig. 14. Same patient as Figure 13 following complete healing. Wolfe grafts to both lower lids.



Fig. 15. Severe scarring of face secondary to thermal burn.



Fig. 16. Same patient as Figure 15 following excision of scars.

have wide clinical trials at the hands of many operators. The method has obviously been on trial for too short a period to frame definite conclusions.

The Newport Naval Hospital at Newport, Rhode Island, has applied this method for the first time on a large scale during the Bennington Disaster. It is now too early to become enthusiastic over the merits of this method. Furthermore, the open air method of treating burns is not applicable in the large deep circular burns of the lower extremities and trunk. It is definitely contraindicated in patients with old chronic burns, since experience has proven that all raw granulating surfaces cannot be exposed to the air without protection. This method has not by any means reduced the mortality rate in severe burns.

Our method of treatment has been the closed pressure dressing method. The chief therapeutic importance of this method cannot be underestimated. The main function of the pressure dressing is probably immobilization, thus minimizing pain, protects against further injury, infection and also against the loss of fluids such as lymph and plasma. During the entire treatment of the burned patient, we must be kind. The morale of the patient must constantly be maintained to the highest possible level. The patient should not be overlooked during rounds. He should be seen by all the members of the staff during rounds, even though he may be in his second or third month of hospitalization. His case must be discussed like any other case. Attempts should be made to early ambulate the patient. In addition, some form of occupational therapy should be instituted as soon as possible, especially when the hands and feet are involved.

Certain complications may arise following the treatment of severely burned patients. These complications may be outlined as follows: Cicatricial contractures, superficial and deep scars, keloid formation and late malignant changes of the ungrafted scar tissue.

Contractures are the end result of a long continued granulated surface which has remained unhealed and uncovered with skin. The avoidance of contractures depends mainly in overcoming scar formation. This means early skin grafting and avoidance of infection. The longer the healing is delayed the heavier and thicker will be the scar. Here we must emphasize that the Reverdin ("pinch") grafts have no place in reconstruction work. They do not prevent scar formation nor do they control its contraction during the healing process. The cosmic results on both the recipient and donor areas is very undesirable. Large doses of ascorbic acid, aid in healing and in minimizing scarring. If there is a small residual scar which has failed to disappear and it presents itself in a very conspicuous area such as the face, it may be excised or abraded by means of autoclaved sandpaper or by Kurtin's planing method.

Keloids and hypertrophic scars are the second most important complication which may occur following a severe burn. A distinction is often made between hypertrophic scar and keloid. The former is excessive production of fibrous tissue within the limits of the wound, while the latter is exactly the same process in the wound, plus a similar invasion and spreading into the surrounding skin. The keloid may attain tremendous thickness and it is persistent while the hypertrophic scar is usually self-limited in duration and gradually disappears in the course of a few months.

There are about three definite conditions which increase the tendency to keloid formation. The first and probably the most common is prolonged infection of granulation tissue. The second are burns by acids. These are very prone to form a heavy scar or keloid. The third influence for the formation of keloids is racial. They are more common in the Negro, Chinese and Japanese as compared to the white race. The management of keloids are too numerous to mention. We have had the best results by excision and skin grafting or excision followed by x-ray therapy soon after the sutures have been removed. Even the grafted area can tolerate small doses of X ray without doing any damage to the graft.

Carcinomas occur very frequently in old burned cases particularly those associated with marked sclerosis and frequent occurring ulcers. In our short

continued on next page



Fig. 17. Extensive keloid formation secondary to thermal burns, involving neck and chest.

experience of treating burns for the past ten years, both in the Army and in civilian life, we have had ten cases of carcinoma develop in patients. These were on the hands, lower extremities and one in the left inguinal region. The treatment of these cases consisted of wide excision and skin grafting.



Fig. 18. Excision of keloid of neck and application of heavy split graft; ten days postoperatively.



Fig. 19. Extensive basal cell carcinoma of the popliteal space secondary to an old thermal burn.

SUMMARY

The numerous mechanical and chemical advances made in industry and at home have stimulated us to more adequate and intensive treatment for severe burns. The object of the treatment is the same as that of other trauma. The treatment of shock is our first consideration. The local wound is then protected from mechanical injury and pathogenic bacteria. Our method of treatment has consisted of gentle cleansing followed by compression dressings into which fenestrated catheters have been incorporated. Debridement has often been hastened by the use of Tryptar. This has always been used after the first dressing. ACTH and cortisone have been used but without any outstanding results as an epithelium stimulator. They do, however, help to minimize pain and produce a state of euphoria. The main objective in the treatment of burns is to minimize early contamination, prevent infection, promote drainage of the burned wound, immobilization of the burned part so as to prevent loss of serum and secure rapid and early healing with a minimal loss of function.

We prefer the closed pressure dressing method in the treatment of burns particularly the circumferential burns and burns of the hands. The exposed method of treatment may be used in massive burns such as might occur in severe explosions or in atomic bomb explosions. This method has shown promise and in the future may prove desirable.

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Fig. 20. Same patient as in Figure 19 following radical excision and application of split grafts; five years postoperatively.

The RHODE ISLAND MEDICAL JOURNAL

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IN MEMORIAM — DR. JOSEPH C. O'CONNELL

TO HAVE BEGUN one's chosen career in the vigor of youth as a general practitioner, and to have ended it at the summit of surgery; to have grown in knowledge, skill and wisdom during the most extraordinary period of progress that medicine has ever seen; to have expended this knowledge, skill and wisdom in the service of one's fellowmen, without distinction of poverty or riches, race, creed or social position; to have responded gladly at all hours of the day or night to the summons for help, with total disregard of personal convenience or fatigue; to have brought solace when one could not bring cure to the bedside of the sick; to have taken time out of one's busy life to further many causes without the ambit of one's profession; to have merited and retained the tribute of gratitude from hundreds of devoted patients; to have been an inspiring leader in the effort to lighten the financial burden of illness; to have died in the full bloom of one's powers, still actively engaged in the practice of one's profession, respected and revered by one's colleagues and a host of other friends — all of these things were accomplished by Dr. O'Connell in the more than fifty years of his medical career. He will be missed by all of us; and the memory of his honorable life and splendid example will surely find an abiding place in the noble company of beloved physicians.

Requiescat in pace.

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MINNESOTA AND DISABILITY INSURANCE

Minnesota is the latest state to file a comprehensive report on the question of whether a compulsory sickness and disability insurance program is a necessity. The findings in Minnesota resulted in the recommendation that no legislation be adopted, and as we read the comprehensive study undertaken by the study commission, including its first-hand appraisal of the plans in Rhode Island, New York and New Jersey, we were struck by the fact that the honor of pioneering this type of legislation has penalized our State in no small measure.

Minnesota, for example, followed in some measure the type of study made in Massachusetts several years ago, whereby the need for cash sickness compensation as a compulsory legislative program was thoroughly explored. As the Minnesota report states, "there has not been presented any picture of economic distress which the people of the state are unable to solve for themselves. Exactly the opposite has been demonstrated, and that is, that under voluntary freedom of action, in those areas where the need or the desire for the same has been existent, tremendous coverage has been rapidly developed by employers and employees joining in the arrangement for the purchase of sickness insurance, paid sick leave, or some similar plan."

The Minnesotans also took time to consider the seriousness of adding new taxes that might penalize industry, particularly new businesses considering locations in their state. We in Rhode Island have been made very conscious of our failure to consider this factor, and in recent years we have taken belated steps to halt the transfer of industries from our confines.

Recognition is also given to the trend of the past decade for industry to work out on a voluntary basis effective programs to assist its workers with satisfactory sick leave plans, and the report notes that "experience would indicate that as soon as industry or business in a state is established and making a profit over a reasonable period of time the pronounced trend is to voluntarily arrange a plan of insurance." We have seen a remarkable support by industry of Blue Cross and Physicians Service in Rhode Island, and we are prompted to think that undoubtedly temporary disability compensation would also have been provided without the far from satisfactory compulsory setup that was "presented" to the workers of the state in 1942 at their own expense.

We conclude with concurrence in the statement of the Minnesota group as being equally applicable to the citizens of Rhode Island when they state "We believe the standard of living and the ability of the people of this state to meet their problems in the face of sickness and accident under free enterprise is equal to or better than most states who have not deemed it necessary to enact such legislation."

FIVE YEARS' EXPERIENCE

In this issue we have published the address by the President of the Rhode Island Medical Society Physicians Service on the occasion of the annual corporation meeting, this time celebrating the completion of five years' service in the voluntary surgical-medical insurance field in Rhode Island. The healthy growth noted in the enrollment and support of the program is a source of encouragement to all of us as we seek to further our aims to extend the insurance method of prepaying for catastrophic illnesses.

Of particular interest, however, is the long range planning and thinking now advanced, and as set forth by Doctor O'Connell in his remarks to the corporation, for major medical expense protection that would start when either the hospital benefits or our Physicians Service benefits have been expended under our existing programs. The emphasis until now has been on the development of what has been for the most part indemnity for the cost of surgical procedures. The new plan would seek to indemnify for the long term illness or accident that can result in bills far in excess of the benefits provided by ordinary insurance contracts.

For example, the major medical expense type of protection already developed in some areas of the country provides maximum benefits up to $5,000, over and above the base benefits now provided by Blue Cross and Blue Shield plans. With this type of coverage the subscriber accepts the responsibility, on his own or through his present insurance coverage, for bills anywhere from $100 to $500, and when his costs for ill health go beyond those indemnities his major medical expense contract would be effective, paying 75% of all subsequent bills up to the five thousand dollar maximum.

As all the voluntary insurance groups have learned, the public is anxious now more than ever before to accept the responsibility of prepaying for hospital and medical care expense. The education has moved fast in the past decade as regards the importance of coping with personal ill health expenses, and in the next decade it is to be hoped the expansion now being contemplated may be fully realized. A comprehensive medical care insurance program must be eventually developed on a voluntary basis; it will never be as effective and satisfactory if it is foisted on the people through compulsory regulations.

ACCREDITATION OF HOSPITALS

From the end of World War I until 1952 the American College of Surgeons performed an outstanding public service in maintaining a nation-wide program of examination and approval of American

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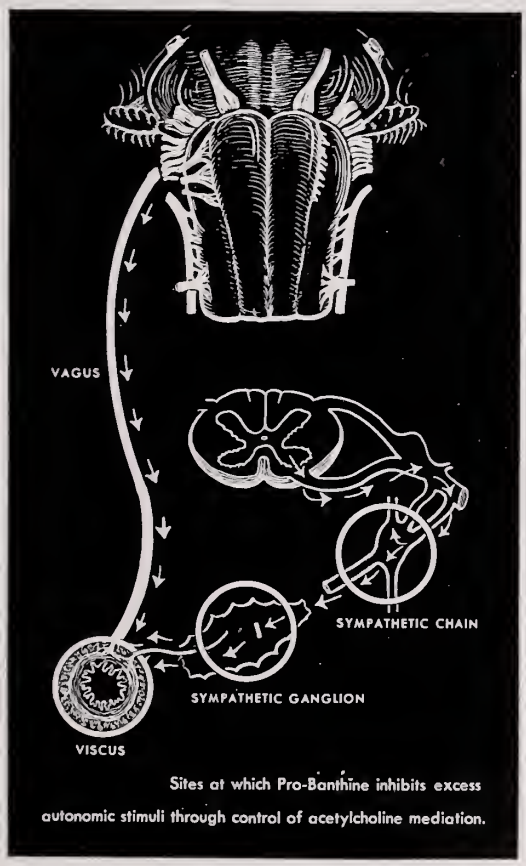
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1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25*:416 (Nov.) 1953.

2. Roback, R. A., and Beal, J. M.: Gastroenterology *25*:24 (Sept.) 1953.

SEARLE

ACCREDITATION OF HOSPITALS

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and Canadian hospitals. The ever increasing hospital expansion following World War II, the development of Blue Cross hospital insurance plans, and the general education of the public in health care put a further burden on the surgical society to continue its work of accrediting hospitals.

Late in 1952 a Joint Commission on Accreditation of Hospitals was established, consisting of representatives of the College of Surgeons, the College of Physicians, the American Medical and Hospital Associations, and the Canadian Medical Association. Named to that Commission as one of the representatives of the American College of Physicians was our Doctor Alex M. Burgess, Sr., of Providence, whose career in medicine needs no elaboration here for our membership.

The JOURNAL is pleased to print in this issue a discussion of the work of the Joint Commission by Doctor Burgess, together with a keen analysis by him of the factors that make for a good hospital.

COMMON SENSE SHOULD PREVAIL

In the past two decades we have witnessed a tremendous development of bureaucracy in our federal government. As a result any attempt to take sensible action to eliminate any program that a federal agency has developed meets with violent opposition from the agency and its particular beneficiaries.

The Defense Department announced that it will shut down the Murphy General hospital, a veterans hospital in Waltham, as an economy measure since the hospital has a small case load. Immediately the pressure was released on the congressional delegation from this area to oppose the economy action, and even though only 101 of the 431 beds in the hospital are being utilized the bureaucrats insist, with the vocal aid of some of their supporters, that the expensive establishment remain in operation.

We commend THE CALL, the excellent daily newspaper published in Woonsocket, for its forthright editorial stand expressed last month on this problem. Said THE CALL:

> "Final decision on whether or not to close Murphy Hospital should be based strictly on facts. The decision should be made on costs, need, number of patients and availability of other facilities. Emotion should play no part in it. Talk of the action being a 'slap in the face' to the New England congressional delegation is just so much poppycock. . . . Common sense and not politics should decide whether or not to close the Murphy Army Hospital on June 30."

The same kind of common sense should be employed in the appraisal of the veterans hospital expansion throughout the country.

THE R. I. MEDICAL JOURNAL

A decent respect for the opinions of mankind and a very natural desire to hear nice things said about us have led us to insert here the letter which we have recently received. We are greatly pleased. Also, we want to record here our appreciation of this nice lady, who even at the time of her great bereavement, could take the trouble to send us this message. We extend to her our esteem and our sympathy in her loss.

THE EDITOR

Edmond F. Cody, M.D.
105 So. Sixth Street
New Bedford, Mass.

R. I. Medical Journal
106 Francis Street
Providence 3, Rhode Island

Dear Sirs:

Dr. Cody died at Sturdy Memorial Hospital, Attleboro, Mass., Feb. 4th, aged 84, of enlarged heart and pneumonia.

Of the many Journals he read so faithfully, I want to tell you, none pleased him more than yours. He may have told you himself, I don't know. However, he never read one without deep appreciation of its dignity.

Yours truly,
s/s DOROTHY L. CODY
(Mrs. Edmond)

PEDIATRIC ESSAY CONTEST

In order to stimulate interest in clinical investigation and accurate reporting of pediatric problems, the New England Pediatric Society is offering an award of $200 for the best paper submitted by an intern, resident or fellow. It should deal with one or more pediatric cases, of special interest or significance, with appropriate supporting literature, and discussion. The prize paper will be submitted for publication in the NEW ENGLAND JOURNAL OF MEDICINE.

Only doctors connected with a hospital or medical school in New England are eligible to enter, provided they are out of medical school five years or less.

The winner of the prize will be announced at the September meeting of the Society.

Papers should be submitted before July 31, 1955, to Dr. Harry Shwachman, Secretary of the New England Pediatric Society, 300 Longwood Avenue, Boston 15, Massachusetts.

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EXTENDING VOLUNTARY MEDICAL CARE COVERAGE IN RHODE ISLAND*

JOSEPH C. O'CONNELL, M.D.

The Author. *Joseph C. O'Connell, M.D., of Providence. President Rhode Island Medical Society Physicians Service; Past President, The Rhode Island Medical Society.*

WHEN the Rhode Island Medical Society initiated its studies and plans for prepaid voluntary insurance programs more than ten years ago it set forth as objectives its desire to 1) increase the extent to which voluntary insurance against the cost of medical care is made available to the people of the State of Rhode Island, 2) to increase the effectiveness of such insurance through the voluntary cooperation of its members, and 3) to make such insurance available at the lowest practicable cost.

We have just completed the fifth year of our Physicians Service program. It is fitting that we consider how well we have achieved the objectives with which we started our community service to provide surgical-medical insurance in Rhode Island.

An outstanding insurance actuary estimated that the number of persons covered by surgical expense insurance in Rhode Island in 1947 totaled 92,000, and the number covered by medical expense insurance 11,000.

At the end of 1953, the Health Insurance Council of the nine associations in the insurance business reported estimates of 514,000 persons covered by surgical insurance, and 470,000 covered by medical expense insurance. Our Physicians Service, offering a combined surgical-medical protection, accounted for 400,000 of those persons.

To these totals we now can add an additional 42,712 new subscribers who enrolled in our program during 1954, bringing our record for the year to 442,777 persons protected as the result of the action of the physicians of this state in forming Physicians Service.

Our second objective is clearly attained by the fact that 817 physicians, numbering practically all the eligible active physicians in the state, have been listed as participating physicians who guarantee the service features of the contract, and the soundness of the entire program.

Thirdly, we continue once again to set a national low level for operating costs, with only 6.1% of our income allocated to the expense of running this state-wide insurance program. To the subscribers went 90.1% of the income, with the small balance after operating expenses turned into the reserve fund to protect the financial status of Physicians Service.

We have quickly arrived at a leveling off position in our development when we must look to the future for expansion of the service in the interests of the people of Rhode Island. In recent months our schedule of indemnities has been completely reviewed and efforts made to eliminate any inequalities in the previously established fees, and to extend the benefits to aid the greatest number of claimants without increasing the premium charge This action, if carried out as planned, will take approximately $100,000 of the money now allocated annually to the reserve funds, thereby leaving a very small margin to add to surplus.

Our claim load has increased greatly during the past year, and I pay particular tribute to those physicians who have served on our Claims Committee which has weekly reviewed the demands upon the service. Although our enrollment increased by little more than 10% in 1954, the total cases processed for benefits increased by nearly 25%. Undoubtedly we shall soon have to consider the possibility of a medical director to supervise the claims work, and in the immediate future it may be advisable to establish a larger membership for the Claims Committee, or to utilize physicians in the various specialties on a rotating plan to assist in the clarification of claims requests.

It is our hope to offer a new subscriber contract, effective March 1, 1955, with changes in the benefits for surgical operations which will also be reflected in increased benefits to the subscriber, when an assistant surgeon and an anesthetist is required. We will also extend the medical benefits, changing the starting day for payments from the fourth to the third day after hospitalization and extending the payments to a limit of $225, which would repre-

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*An address to the Corporation of the Rhode Island Medical Society Physicians Service at its Sixth Annual meeting, at Providence, Rhode Island, January 26, 1955.

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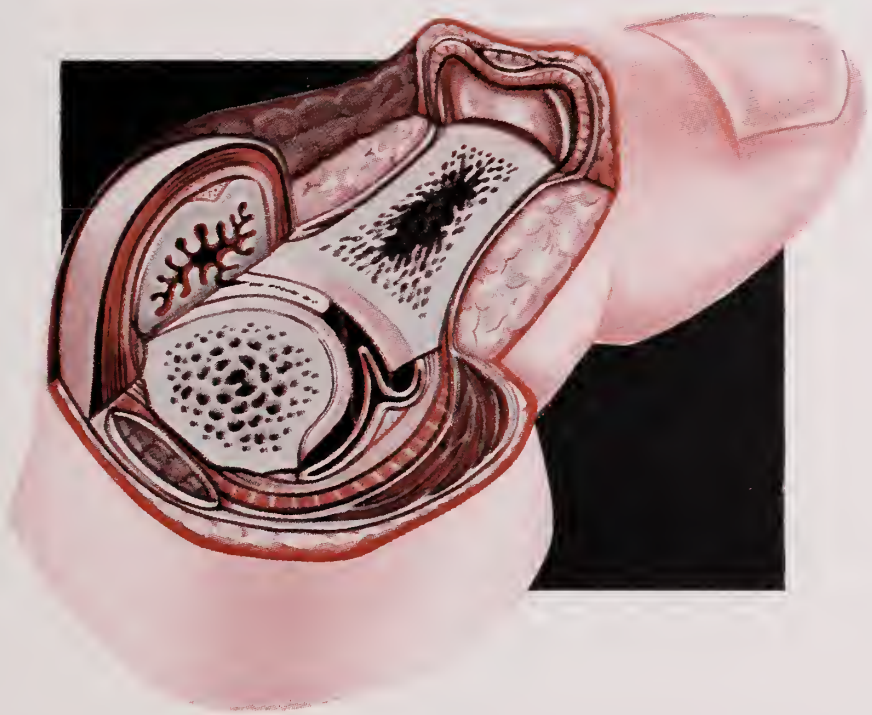
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*Bunim, J. J.: Research Activities in Rheumatic Diseases, Pub. Health Rep. 69:437, 1954.



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THE COMMITTEE ON MEDICAL DEFENSE AND GRIEVANCE

ROLAND HAMMOND, M.D.

The Author. *Roland Hammond, M.D., of Providence, Rhode Island. Chairman for eleven years of the Committee on Medical Defense and Grievance of the Rhode Island Medical Society; Past President, Rhode Island Medical Society.*

ELEVEN YEARS' SERVICE as chairman of this important committee of the Rhode Island Medical Society has been a valuable experience from which many useful lessons may be drawn. In retrospect, our committee, one of the first of its kind on a state-wide basis was organized in 1928, in an effort to give to the public and to the medical profession deserving protection.

The previous chairman, the late Dr. Charles F. Gormly, had organized the work of the committee in an orderly program. Here was a situation made to order and patterned for the guidance of future committees. My predecessor, by his tact and ability to inspire confidence, had gained the good will of the medical and dental professions as well as the respect of lawyers, insurance adjusters, the courts and other interested parties.

As the name implies, the committee has two functions, the first of which is to receive and adjudicate complaints by displeased patients concerning conduct, treatment, fees or any other possible reason for discontentment. The second function is to hear and evaluate cases in which legal action against a Fellow of the Society is threatened or is already in progress.

Grievance complaints are brought to the attention of the committee by letters addressed to the Rhode Island Medical Society, to the executive office or directly to the physician. All these communications are carefully and scrupulously investigated. It has been my experience that many complaints are due to misunderstanding, to lack of accurate information or to dissatisfaction with the conduct of the case. Very often, a word carelessly dropped by the attending physician or a solicitous friend may start a train of thought which builds up with the passage of time. Criticism of the physician's fee is probably the origin of most grievance cases. It is interesting to note that most letters stated that the physician should be deprived of his right to practice medicine. How do we approach processing of these problems? After the facts have been assembled, a tactful letter from the committee is usually sufficient to explain the confusion. If this procedure proves unsuccessful, the problem is brought before the full committee for adjudication and disposal. Attempts to bring the complainants before the committee to state their grievance have been rather disappointing. These persons have declined either to follow the recommendations of the committee to which they had previously agreed or have sent notice that they would not press the charges.

In cases of malpractice, action is usually initiated by a letter to the attending physician from the patient's lawyer. As soon as this occurs, the physician reports the circumstances of the case to the executive office of the society or to a member of the committee, and is directed to contact his insurance carrier without delay. It then becomes expedient for the physician to prepare forms listing his qualifications and entire background as well as a complete history of the case. He is further expected to submit his office records, an exact and complete copy of the hospital records, x-ray films when available, and supplementary information from all physicians who have been associated with him in the treatment of the case. When the data is assembled, copies are sent to the individual members of the committee for their study. At a convenient date, a meeting of the committee is called, and the physician as well as the attorney representing the insurance carrier are invited to attend. In some cases, the physician has also retained the services of a personal attorney, and in such an event this attorney is urged to be present. The meeting is held according to parliamentary procedure and the members of the committee sit as a tribunal, hearing a complete recitation of the case by the physician. Examination and cross-examination follow until the case has been meticulously explored. After the evidence and all hypotheses have been fully discussed, the physician and attorney (or attorneys) are excused while the committee deliberates the merits of the case and arrives at a decision. The meeting is then reconvened with the physician and the attorney (or attorneys) returning to the meeting to receive the decision of the

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*Smith, R. T., New York Med. 8:16, 1952.



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MEDICAL DEFENSE AND GRIEVANCE

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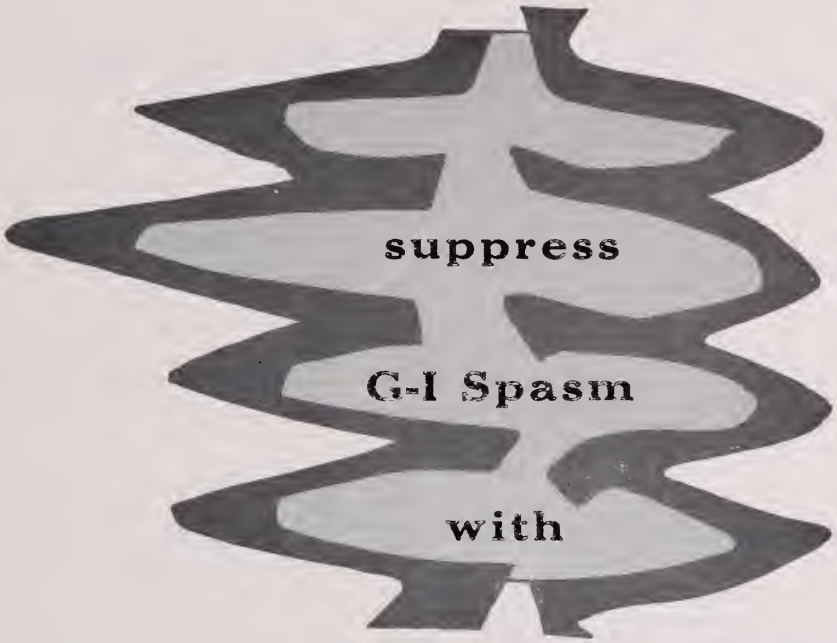
committee. In a few cases, where the situation requires highly specialized knowledge, the chairman is instructed to have two or more specialists in attendance so that their opinions will help guide the committee in its final action.

What lessons are to be learned from this wide and illuminating experience? How can the physician-patient relationship be improved? How best to clarify in the public mind the confusion which exists as to the duties and obligations of the medical profession to the public, and conversely the responsibility of the public to cooperate with the medical profession? Articles appearing from time to time in lay papers and magazines fail to contribute to the solution of the problem, but frequently add to the existing confusion. One must conclude that education of the public is necessary and is best accomplished by day-to-day contacts between physician and patients. These heart-to-heart talks will result in clarifying many aspects of the problem which might otherwise remain obscure. Public lectures on medical subjects and radio and TV programs are most valuable media for instruction concerning the nature of a disease and its treatment.

One cannot emphasize too strongly that the physician is under heavy responsibility to his patient or family to explain as fully as his judgment dictates the circumstances and aspects in the individual case. Generally, physicians should never minimize any condition, and the fee situation should be frankly discussed at an early date with responsible parties. Consultations should be held whenever there is any doubt as to the outcome of the illness, or if any evidence of dissatisfaction in the family is detected. Consultations also serve to inspire confidence and in many instances have clarified puzzling or difficult situations. Of inestimable value is another opinion by a qualified expert which often has saved many a practitioner from both professional and legal embarrassment.

It is advisable that the profession be far more circumspect than ever in view of the fact that many law suits are being instituted today, because the public is aware that physicians are now almost universally protected by malpractice insurance. It must be noted also that many patients have no particular grievance against their doctor but this procedure seems to be an easy way to try to collect money.

As a final observation, verdicts in much larger amounts are now being made in the courts than was the practice several years ago. Consequently, it behooves every physician to review his insurance coverage and to be sure that he is adequately protected from financial loss.



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C I B A *Summit, N. J.*

EXTENDING VOLUNTARY MEDICAL CARE COVERAGE IN RHODE ISLAND

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sent physician indemnities for persons hospitalized for as many as fifty-six days.

These developments will carry us to the full limits of our present subscription rates and will use up approximately two-thirds of our annual surplus, leaving a close margin for emergencies. We are one of the few organizations in the entire country that has not increased its charges in the past five years, a truly remarkable tribute to the physicians of Rhode Island who have given their unselfish support to this community program in order to establish it on a solid basis.

We are still reluctant to contemplate a premium increase. But if we are to increase benefits and offer to the people of this state a more comprehensive coverage for their catastrophic illnesses, we must look forward to some increase to guarantee the continued solvency of the program, and the establishment of additional benefits.

Of interest to all of us is the problem of providing a major medical expense protection that would start when either the hospital benefits or the physician's services have been expended under our existing Blue Cross and Physicians Service plans. Our plans were designed to provide families with basic protection for hospital and medical care. However, more and more families have indicated a willingness and a desire to have some insurance against the cost of an extremely serious illness or accident that can result in bills in excess of those likely to be covered by our programs.

This major medical expense type of protection might provide maximum benefits up to $5,000, over and above the base benefits now provided. In general this type of coverage might reimburse the subscriber for ill-health expenses above an amount ranging from $100 to $500 since these deductible amounts are covered by usual policies in most instances. The insured person would be paid a percentage, possibly as much as 75%, of the ill-health expenses he incurs above the deductible amount, and he in turn would agree to pay the remaining per cent.

Whether we can introduce this type of coverage here remains a matter for future consideration. I report it to you at this time because I have named, with the approval of the board of directors, a committee to explore the question with the Hospital Service Corporation of Rhode Island.

The details of the development of Physicians Service in 1954 will be set forth for you in reports of the secretary and the treasurer.

On this occasion I again sincerely thank, both for the medical profession and for the people of the state, the representatives of the public—Messrs. James R. Donnelly, Emil E. Fachon, Walter F. Farrell, John J. Halloran, Felix A. Mirando, and George R. Ramsbottom—for their loyal and conscientious service as members of the board of directors. We are truly indebted to these public spirited citizens for their assistance in making the Rhode Island Medical Society Physicians Service one of the finest programs of its type in the nation.

To our administrative staff and executive officers go our renewed appreciation for jobs well done during 1954.



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2. *Do not advise* a patient he is covered under *Physicians Service* unless YOU ARE CERTAIN.

   Every subscriber is issued a blue identification card. Ask your patient to show this card to you, and then note the identification number on your records.

3. *When submitting your claims* be sure that the complete answer is given to every question.

   Full names, no abbreviations. Identification number of the subscriber. Diagnosis. Code number from master schedule of indemnities to indicate the procedure for which benefit is claimed. Name of assistant surgeon and anesthetist.

4. *File claims PROMPTLY* in order that payments may not be delayed to you or the subscriber.

   Don't wait until you have an accumulation of claims. Make daily mailings, if possible.

RHODE ISLAND MEDICAL SOCIETY
PHYSICIANS SERVICE

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting Held on January 26, 1955

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library, Wednesday, January 26, 1955. The meeting was called to order by the President, Dr. Henri E. Gauthier, at 8:40 p.m.

The following delegates were in attendance:

Kent County: Peter C. Erinakes, M.D.; Edmund C. Hackman, M.D.; Russell P. Hager, M.D. *Pawtucket District:* Francis E. Hanley, M.D.; Edwin F. Lovering, M.D.; Adrien G. Tetreault, M.D.; Henry E. Turner, M.D.; Howard W. Umstead, M.D. *Washington County:* James A. McGrath, M.D. *Providence Medical Association:* Charles J. Ashworth, M.D.; Irving A. Beck, M.D.; Alex M. Burgess, Jr., M.D.; Frederic J. Burns, M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; William B. Cohen, M.D.; Michael DiMaio, M.D.; William J. H. Fischer, Jr., M.D.; John C. Ham, M.D.; Albert H. Jackvony, M.D.; Ernest K. Landsteiner, M.D.; William S. Nerone, M.D.; Arnold Porter, M.D.; Alfred L. Potter, M. D.; William A. Reid, M.D.; Louis A. Sage, M.D.; James J. Sheridan, M.D. *Officers of the RIMS:* Henri E. Gauthier, M.D.; John G. Walsh, M.D.; Frank B. Cutts, M.D.; Thomas Perry, Jr., M.D. *Retiring President of the RIMS:* Earl F. Kelly, M.D. *Woonsocket District:* Alfred E. King, M.D.; Francis P. Vose, M.D. *Delegate to the A.M.A.:* Charles L. Farrell, M.D. *President of Physicians Service:* Joseph C. O'Connell, M.D.

Also present were Mr. John E. Farrell, Executive Secretary, and Dr. Louis I. Kramer, Chairman of the Committee on Diabetes.

REPORT OF THE SECRETARY

Dr. Thomas Perry, Jr., Secretary, read his report of the actions of the previous two meetings of the Council of the Society, copy of which had been submitted in advance to each member of the House of Delegates. The report follows:

The Council has held two meetings since the last session of the House of Delegates. Among the matters resolved by the Council were the following:

1. Approval was given actions of the President whereby he—

Referred to the Committee on Child Health Relations a request from the Parents Council for Retarded Children of Rhode Island for a meeting to discuss problems of that organization.

Accepted for the Society an invitation for himself and the Executive Secretary to serve as members of a New England local arrangements committee for the Interim Meeting of the American Medical Association to be held in Boston in December, 1955. The Council also authorized the President to pledge the Society's proportionate share towards the expense to be incurred by the medical societies of New England for a dinner for the delegates of the American Medical Association.

Issued a statement during National Nurse Week supporting the efforts of the Rhode Island State Nurses Association to focus attention on the needs of nursing and nursing education.

Arranged for meetings between the Society's Committee on Industrial Health and the new State Workmen's Compensation Commission.

Arranged for a meeting of officers and other representatives of the Society with Dr. Frank Wilson, Director of the Washington Office of the American Medical Association, to discuss national health legislation.

Wrote a letter to the Fellows of the Society explaining in detail the reason for the increase in the annual assessment of dues.

2. The Council notified the Amalgamated Meat Cutters and Butcher Workmen of North America of the interest of the Society in the campaign to secure effective poultry regulation and inspection.

3. It authorized the President to name a representative to attend the annual meeting of the American Medical Education Foundation.

4. It authorized the President to notify the Governor of the State of Rhode Island of the Council's attitudes relative to a regional compact of higher education, particularly noting that a survey of the needs of the state should be first undertaken before legislative commitment is made.

5. It authorized the Executive Secretary to represent the Society at a meeting of the Medical Exhibitors Association in New York.

6. It voted to renew the Society's membership in the National Conference of Presidents and Other Officers of State Medical Associations.

7. It authorized the President to appoint two members of the Cancer Committee to represent the Society, and it further authorized these two members to initiate for the Society the establishment of a proposed Advisory Coordinating Committee for Rhode Island to effect better organization in cancer education and control.

8. It authorized the Secretary to represent the Society at a community meeting to be called to discuss the formation of a United Fund as a solution to the present problem of multiple charitable campaigns.

9. It approved of a recommendation by the Treasurer to transfer the cash reserve of the Frank L. Day Fund to the

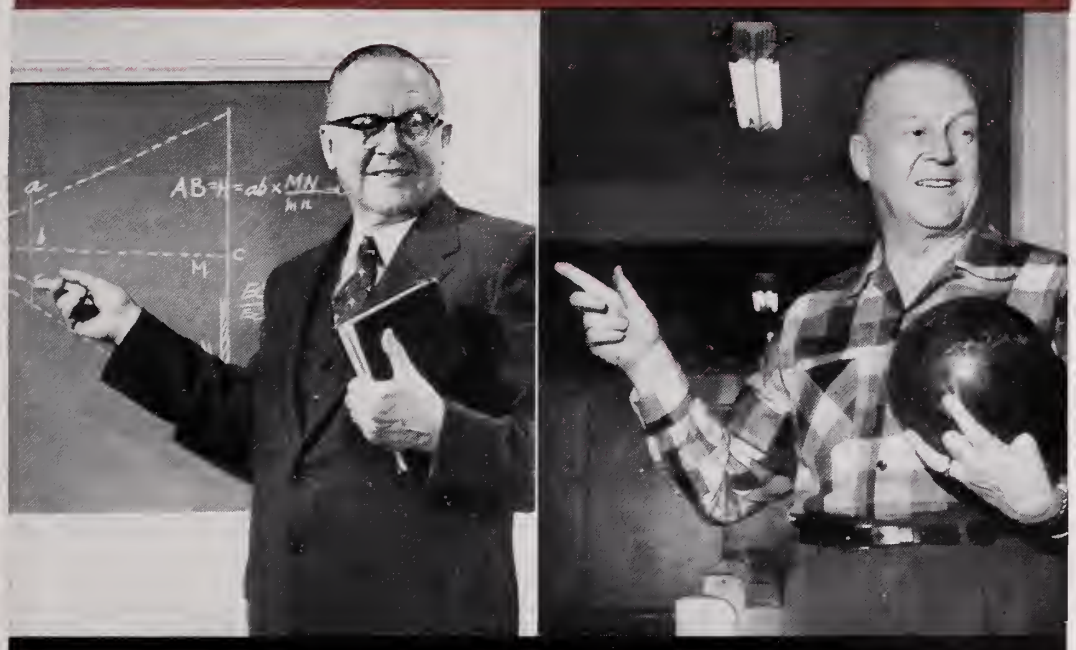
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REFERENCE: 1. Kirwin, T. J., Lowsley, O. S., and Menning, J., Am. J. Surg. **62**.330-335, December 1943.

HOUSE OF DELEGATES

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general account of the Society, but crediting it to the Day Fund. This action will eliminate a separate check book, and deposit record for the Day Fund, and will place it within the pattern adopted for all the other special accounts of the Society.

The Council also approved of recommendations from the Trust Department of the Industrial National Bank relative to changes in some of the investments in the general account administered for the Society by the bank.

10. It approved of a report from the Committee on Professional Relations and Hospitals to be submitted to the House of Delegates.

11. It authorized the President and the Chairman of the Committee on Veterans Affairs to secure, if possible, a delegate to represent the Society at the meeting called by the American Medical Association to be held in February, 1955. It also voted that the Committee on Veterans Affairs explore the possibility of a meeting with leaders of veterans' organizations in Rhode Island to discuss problems relating to the medical care of veterans.

12. It authorized the Trustees of the Medical Library Building to proceed with necessary repairs to the building resulting in the main from hurricane damage.

13. It voted that members in their first year of practice shall be assessed half of the annual dues if elected to membership after June 30, and shall be subject to the full assessment effective January 1 of the ensuing year.

14. It voted that members resuming private practice after a tour of military service shall be exempt from the payment of dues for six months of the year in which they resume private practice.

15. It voted that the Interim Meeting of the Society for 1955 be held on Wednesday, October 26th, at a time and place to be decided by the Committee on Scientific Work and Annual Meeting.

The President briefly commented on the meeting in Boston relative to plans for the Interim Meeting of the American Medical Association to be held in December, 1955.

Action—It was moved that the report of the Secretary be approved and placed on file. The motion was seconded and adopted and the report is made part of the official minutes of the meeting.

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Recommendations of the Council

The Secretary read the recommendations from the Council, notice of which had been sent to each member of the Society, as follows:

1. The Council recommends to the House of Delegates the nomination of Drs. Charles J. Ashworth and Charles L. Farrell to be the Society's representatives on the Board of Directors of the Hospital Service Corporation of Rhode Island.

Action—It was moved that Doctors Charles J. Ashworth and Charles L. Farrell be nominated to serve on the Board of Directors of the Hospital Service Corporation. The motion was seconded and adopted.

2. The Council recommends that the House of Delegates adopt the regulation that no Fellow of the Society shall list his specialty under any condition in the classified section of any telephone or non-medical directory published for use in Rhode Island.

Action—After discussion of the recommendation a motion was made that this action be taken and the recommendation be adopted as the policy of the Society. The motion was seconded and passed.

3. The Council recommends that the House of Delegates request the Providence Medical Association to extend to all members of the Society an invitation to attend its meeting on March 7, 1955, to hear Dr. Frank Dickinson, Director of the Bureau of Medical Economic Research of the American Medical Association, discuss the "Retirement Problem of the Doctor"; and further, that subsequent to this meeting on March 7 each district society poll its membership by written ballot, to be supplied by the State Medical Society, listing the issues involved regarding Social Security coverage for physicians, and the summary of such district society polls be reported to the House of Delegates at its meeting in April, 1955.

Action—It was moved that the recommendation be adopted. The motion was seconded and passed.

Nominations for Medical Members of the Physicians Service Board of Directors

The Secretary noted that the members of the House had been informed of the present medical roster of the Board of Directors of Physicians Service, the terms of four expiring as of this date.

Dr. Gauthier called for nominations to be made to the Corporation of Physicians Service.

The following were placed in nomination: Charles L. Farrell, M.D., Pawtucket; James C. Callahan, M.D., Newport; Henri E. Gauthier, M.D., Woonsocket; and Hartford P. Gongaware, M.D., Westerly.

Action—It was moved that the list of nominations be closed. The motion was seconded and adopted.

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HOUSE OF DELEGATES

continued from page 170

It was moved that the nominees be submitted to the Corporation of the Rhode Island Medical Society Physicians Service to serve as members of the Board of Directors until the annual meeting of that Corporation in January, 1958. The motion was seconded and adopted.

Recess for Physicians Service Meeting

It was moved that the House of Delegates recess in order that the Corporation of the Rhode Island Medical Society Physicians Service might hold its annual meeting. The motion was seconded and the House recessed at 9:12 p.m., and reassembled at 9:45 p.m.

Report of the Delegate to the A.M.A.

Dr. Charles L. Farrell reviewed the work in general of the House of Delegates of the American Medical Association, and in particular at the recent meeting held in Miami, Florida. He discussed the actions taken by the House, and he stressed the great amount of work that is done by the Committees in the interests of the medical profession.

Action—It was moved that the report of the Delegate to the A.M.A. be accepted. The motion was seconded and adopted.

* * *

The president noted that Dr. Farrell was retiring as Delegate after six years of service, and he moved that the House give a rising vote of appreciation to Dr. Farrell for his outstanding work. The motion was seconded and unanimously adopted.

Resolutions from District Societies

The President called for the submission of any resolutions from district societies. There were no resolutions submitted.

Report of the Committee on Diabetes

Dr. Louis I. Kramer, Chairman of the Committee on Diabetes, gave an oral preliminary report on the 1954 Diabetes Detection Campaign conducted by his Committee.

Action—It was moved that the report be received. The motion was seconded and adopted.

Committee on Professional Relations and Hospitals

Dr. Charles J. Ashworth reported on the developments for the formation of a local Joint Commission for the Improvement of the Care of the Patient, under the auspices of the Society, the Hospital Association of Rhode Island, and the State Nursing Associations. He reported that his Committee recommended the participation of the Rhode Island Medical Society with this Joint Commission.

Action—It was moved that the report of the Committee on Professional Relations and Hospitals be received and its recommendation adopted. The motion was seconded and passed.

Committee on Scientific Work and Annual Meeting

Dr. Earl F. Kelly reported on the preliminary program for the Annual Meeting of the Society to be held in May, 1955, and he read the list of speakers who had accepted invitations to address the Society.

Committee on Industrial Health

In the absence of Dr. Stanley Sprague, Chairman of the Committee on Industrial Health, the Secretary read the recommendations in the report of the Committee, which had been submitted in advance to each member of the House.

Action—It was moved that the report of the Committee on Industrial Health and the recommendations relative to the adoption of the "Guiding Principles of Occupational Medicine," and the sending of a questionnaire to the entire membership be approved. The motion was seconded and adopted.

Miscellaneous

The Executive Secretary asked for a ruling regarding the listing on signs by physicians at their office, citing recent experiences regarding problems that have arisen whereby physicians had listed their specialty on their office sign.

Action—After brief consideration it was moved that the problem be referred to the Council for its consideration and a report to the House of Delegates with recommendations at the next meeting. The motion was seconded and adopted.

Adjournment

The House was adjourned at 10:30 p.m.

Respectfully submitted,

THOMAS PERRY, JR., M.D., *Secretary*

concluded on page 174

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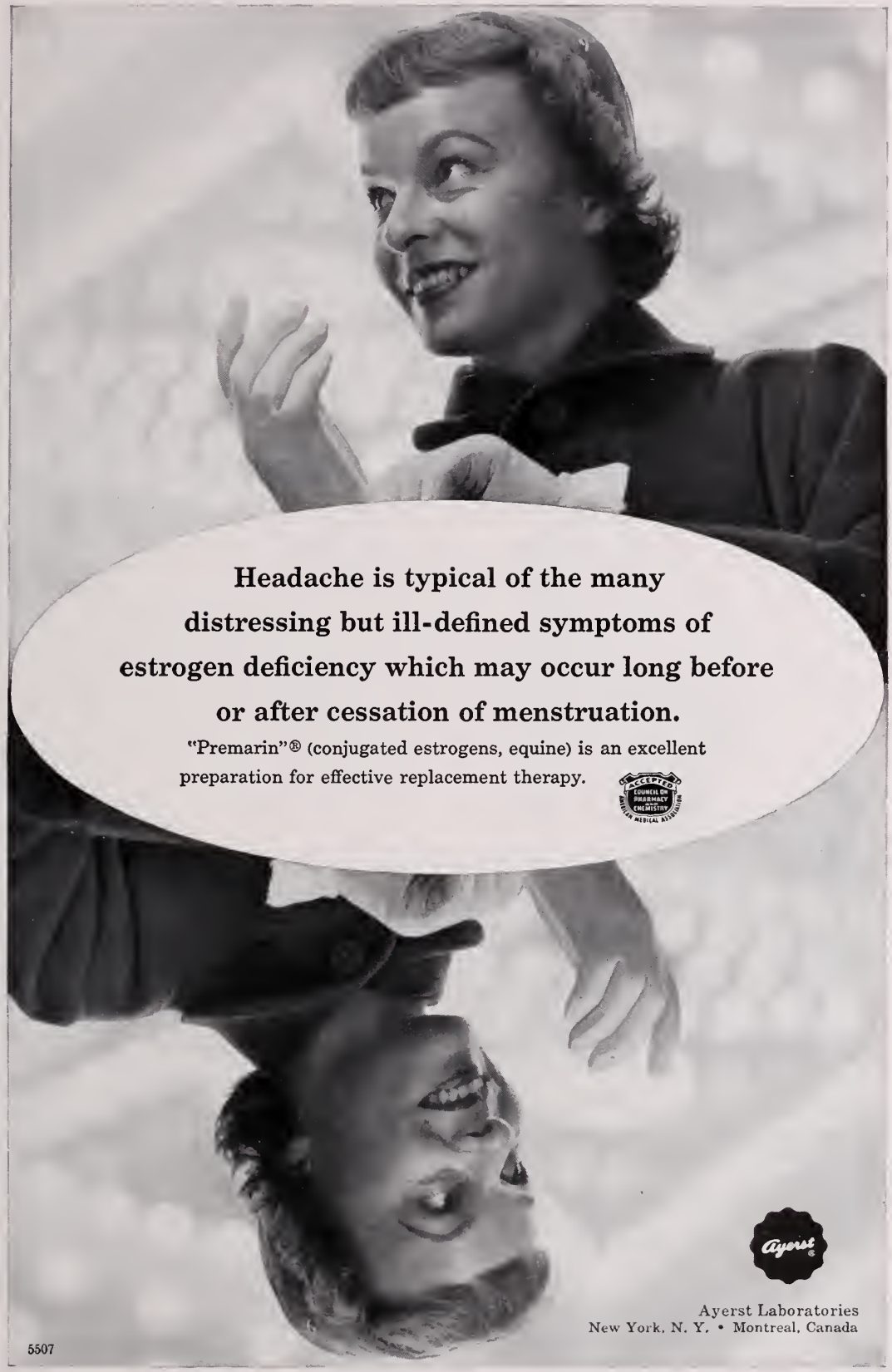
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HOUSE OF DELEGATES

concluded from page 172

Report of the Committee on Industrial Health

At its annual session in San Francisco in June, 1954, the House of Delegates of the American Medical Association adopted a resolution that the Council on Industrial Health be instructed to refer its Guiding Principles of Occupational Medicine to state and local county medical societies for endorsement as acceptable criteria under which industrial health services can properly develop.

These Guiding Principles have been reviewed by the Society's Committee on Industrial Health. They define occupational medicine and outline the scope of service for an adequate industrial health program. The phases of prevention, medical examinations, health education and counseling, free choice of physician to render medical and surgical care under compensable disability laws, as well as for noncompensable disability, are all briefly set forth in the brochure of Principles.

Of equal importance to us is the incorporation as guiding principles of provisions relative to the professional status of the physician in charge of an industrial medical service, the relationship of the employer and the employee to the industrial physician, and the role of the nurse, consultants, official health and rehabilitation agencies as well as medical organizations.

The Committee on Industrial Health recommends to the House of Delegates the adoption of these Guiding Principles of Occupational Medicine, as set forth by the Council on Industrial Health of the American Medical Association, for all physicians in Rhode Island who may engage in any industrial medical practice.

For some time the Committee has felt the need for a record of the number of physicians engaged in industrial work in Rhode Island, the extent of their work, and the companies providing industrial medical care. From time to time the executive office has received requests for names of physicians interested in engaging in part-time industrial medical work, and a listing of physicians interested should be readily available.

Therefore the Committee requests authorization to send a questionnaire to the entire membership of the Society to secure information that will provide a complete listing of physicians engaged in part-time industrial medical work, as well as a list of men desirous of participating in such programs.

Respectfully submitted,
STANLEY SPRAGUE, M.D., *Chairman*

SAVE . . . MAY 4 and 5
144th Annual Meeting of the
RHODE ISLAND MEDICAL SOCIETY

RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

Report of the Sixth Annual Meeting of the Corporation, January 26, 1955

THE SIXTH Annual Meeting of the Corporation of the Rhode Island Medical Society Physicians Service was held at the Rhode Island Medical Society Library, Wednesday, January 26, 1955. The meeting was called to order by the President, Dr. Joseph C. O'Connell, at 9:12 p.m.

The following members of the Corporation were in attendance:

Charles J. Ashworth, M.D.	Earl F. Kelly, M.D.
Irving A. Beck, M.D.	Alfred E. King, M.D.
Frederic J. Burns, M.D.	Ernest K. Landsteiner, M.D.
Wilfred I. Carney, M.D.	Edwin F. Lovering, M.D.
Francis H. Chafee, M.D.	James A. McGrath, M.D.
William B. Cohen, M.D.	William S. Nerone, M.D.
Frank B. Cutts, M.D.	Joseph C. O'Connell, M.D.
Michael DiMaio, M.D.	Thomas Perry, Jr., M.D.
Peter C. Erinakes, M.D.	Arnold Porter, M.D.
Charles L. Farrell, M.D.	Alfred L. Potter, M.D.
Wm. J. H. Fischer, Jr., M.D.	William A. Reid, M.D.
Henri E. Gauthier, M.D.	Louis A. Sage, M.D.
J. Merrill Gibson, M.D.	James J. Sheridan, M.D.
Edmund C. Hackman, M.D.	Adrien G. Tetreault, M.D.
Russell P. Hager, M.D.	Henry E. Turner, M.D.
John C. Ham, M.D.	Howard W. Umstead, M.D.
Francis E. Hanley, M.D.	Francis P. Vose, M.D.
Albert H. Jackvony, M.D.	John G. Walsh, M.D.

Also present was Mr. John E. Farrell, Executive Secretary.

Annual Report of the Secretary

Dr. Ernest K. Landsteiner, Secretary, read his annual report, copy of which was submitted to each member of the Corporation. The report is made part of the official minutes of the meeting.

Action—It was moved that the report of the Secretary be received and placed on file. The motion was seconded and adopted.

Annual Report of the Treasurer

Dr. Charles J. Ashworth, Treasurer, read his annual report, in which he reviewed the financial status of Physicians Service in 1954, and at the completion of its fifth year of operation. This report is made part of the official minutes of the meeting.

Action—It was moved that the report of the Treasurer be received and placed on file. The motion was seconded and adopted.

Election of Members to the Board of Directors

The Secretary reported that the House of Delegates of the Rhode Island Medical Society had nominated, to serve for three-year terms, until the annual meeting of the Corporation in 1958, the following:

Charles L. Farrell, M.D., Pawtucket
Henri E. Gauthier, M.D., Woonsocket
James C. Callahan, M.D., Newport
Hartford P. Gongaware, M.D., Westerly

Action—It was moved that the physicians nominated by the House of Delegates be elected by the Corporation. The motion was seconded and adopted.

Adjournment

The business of the Corporation completed, the President declared the meeting adjourned at 9:45 p.m.

Respectfully submitted,
ERNEST K. LANDSTEINER, M.D., *Secretary*

Annual Report of the Secretary

The Board of Directors of Physicians Service has held four meetings during the past twelve-month period to supervise the affairs of the Corporation. In addition the members of the Board have served as active participants on five committees—the Executive Committee, Finance Committee, Professional Advisory Committee, Joint Operations Committee, and Claims Committee. The work of these various committees throughout the year has done much to further the progress of your program.

The Board elected as its officers for the year the following:

Joseph C. O'Connell, M.D.	*President*
Rocco Abbate, M.D.	*Vice-President*
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Charles J. Ashworth, M.D.	*Treasurer*

As representatives of the public, the Board re-elected the following:

Mr. James R. Donnelly, Mgr., Pawt. Branch, R. I. Hosp. Trust Co.
Mr. Emil E. Fachon, President, Bulova Watch Company

continued on next page

Mr. Walter F. Farrell, Chr., Bd. of Dir., Industrial Nat'l Bank

Mr. John J. Halloran, Commercial Supt., N. E. Tel. & Tel. Co.

Mr. Felix A. Mirando, President, Imperial Knife Company

Mr. George R. Ramsbottom, President, Seekonk Lace Company

A cost analysis was completed during the year of Physicians Service which has been the basis for a revised Joint Operations Agreement effective January 1, 1955.

The problem of payments to non-participating physicians has been subject to review and study, and new assignment to pay forms drafted. The Master Schedule of Indemnities has been reviewed by committees of the Rhode Island Medical Society representing the various specialties, and revisions to eliminate inequalities in the Schedule have been adopted.

The Board authorized the President to name a committee to study the question of long term medical expense, and to consider possible expansions of the Physicians Service program to offer coverage in cooperation with the Blue Cross program of hospitalization.

The membership increased by 42,712 subscribers during the year, continuing Physicians Service as one of the leaders in the nation in enrolling the eligible population in its area.

Appended to this report is a comparative summary of the years 1953 and 1954 as prepared by the Executive Director.

Respectfully submitted,

ERNEST K. LANDSTEINER, M.D., *Secretary*

Annual Report of the Treasurer

INCOME AND EXPENSES: Subscription income for the year 1954 totaled $4,089,424.37 compared to $3,345,928.81 in 1953, or an increase of $743,495.56 or 22.22%.

Income on invested funds amounted to $24,672.30 compared to $16,622.71 in 1953, or an increase of $8,049.59.

Surgical-Medical expenses, or amounts paid to physicians in 1954, amounted to $3,707,803.48 compared to $2,984,315.50 in 1953, an increase of $723,487.98 or 24.24%.

Operating expenses in 1954 were $249,817.34 compared to $210,311.60, an increase of $39,505.74 or 18.78%.

The net amount added to reserves for 1954 totaled $156,475.85, compared to $167,924.42 in 1953.

BALANCE SHEET—DECEMBER 31, 1954. Rhode Island Medical Society Physicians Service held assets in the amount of $1,820,771.41 compared to $1,549,533.86 a year ago. Cash on hand and in banks totaled $250,612.60; Accounts Receivable, $373,778.90; Investments in Government Bonds, $1,196,379.91; Total Liabilities as of December 31, 1954 totaled $1,302,362.26, compared to $1,099,879.56 a year ago. The Liabilities consisted of Accounts Payable, $341,577.06, Required Accrual for Unreported Cases, $297,723.00, Required Accrual for Maternity Cases, $475,091.00, and Unearned Subscriptions, $187,971.20.

The Reserves as of December 31, 1954 amounted to $518,409.15 compared to $449,654.30 a year ago; an increase of $68,754.85 or 1.7% of the Income for the year.

You can see from the foregoing figures that while the financial soundness of the Plan has been maintained that we really had expenses requiring nearly all of our income.

In regard to reserves—many of our doctors seem concerned that the Corporation has set aside the reserves that we have.

We must bear in mind that we now have a Plan in which 442,777, or 56% of the citizens of our State are members. We are therefore obligated to provide protection for them in the form of surgical-medical benefits in accordance with the terms of a contract which they have purchased. The Directors of your Corporation, as well as the Insurance Commissioner of the State of Rhode Island, (through his supervision) are charged with the responsibility of operating the Plan so that the best interests of the public will be served. This means the ability to pay claims to subscribers or participating physicians promptly.

It is therefore required that an accrual be maintained at all times equivalent to the maternity claims paid for the last nine months. These now total $475,091.00. The Insurance Commissioner has also required us to set up a Statutory Reserve of $300,000.00 to take care of any unusually heavy demand that might be placed on the Corporation. This leaves only $218,409.15 unallocated in our reserves to carry us over any period where expenses exceed income, as they do in several months during each year, and as they probably will to a greater extent during the year 1955. We have only about two (2) months of medical-surgical expenses in our reserves; whereas the Blue Shield Plan in Massachusetts has 5.7 months in reserve, Connecticut 4.1 months, and the average of 23 Blue Cross plans our size have 3.8 months.

In view of this it may be necessary in the future to build reserves more adequately than they are at present. I am sure that we all want our plan to continue to operate on the same sound basis that has been maintained since it started.

CHARLES J. ASHWORTH, M.D., *Treasurer*

Rhode Island Medical Society Physicians Service—Comparative Data

	Year 1953	Increase or (Decrease)	Year 1954
Subscribers	400,065	42,712	442,777
% Blue Cross Direct Payment Members Enrolled	58.7%	7.1%	65.8%
% Blue Cross Group Members Enrolled	68.9%	8.1%	77.0%
% State's Eligible Population Enrolled	50.5%	5.4%	55.9%
Number of Firms Buying Physicians Service	575	106	681
Amount Paid to Participating Physicians	$2,486,094.49	$625,025.51	$3,111,120.00
Amount Paid to Non-Participating Physicians:			
In State			$268,506.00
Out of State			$328,177.48
Total	$498,221.01	$98,462.47	$596,683.48
Total Paid to Physicians Since Start of Plan	$7,076,757.11	$3,111,120.00	$10,187,877.11
Number of Participating Physicians	810	7	817
Total Assets	$1,549,533.86	$271,237.55	$1,820,771.41
Investments	$896,504.91	$299,875.00	$1,196,379.91
Total Income	$3,362,551.52	$751,545.15	$4,114,096.67
Total Reserves	$449,654.30	$68,754.85	$518,409.15
Reserve for Maternity Benefits	$387,370.00	$90,721.00	$478,091.00
Operating Expenses	$210,311.60	$39,505.74	$249,817.34
Operating Expenses per Subscriber	$.618	($.011)	$.607
% Income for Operating Expenses	6.2%	(0.1%)	6.1%
% Income for Claims	88.8%	1.3%	90.1%
Total Cases Processed	80,393	18,747	99,140
Maternity Cases*	7,708	1,580	9,288
Number of Months Expenses in Reserve	3.1 Mos.	(0.1)	3.0 Mos.
Massachusetts Blue Shield			5.7 Mos.
Connecticut Medical Service			4.1 Mos.
Average of 23 Blue Shield Plans our Size			3.8 Mos.

*Included in Total Cases
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HEAR . . .

SYDNEY A. GELLIS, M.D., *of Boston*

and

DONALD A. DUKELOW, M.D., *of Chicago*

at the April 4th meeting of the

PROVIDENCE MEDICAL ASSOCIATION

WHAT MAKES A GOOD HOSPITAL?

continued from page 146

search may be considered minimum, there should be someone who is interested in seeing that the important unusual case, which can occur in the small hospital as well as in the large one, is recorded in the literature.

Another important committee is the Tumor Board, a group on which several services are represented, whose function it is to render a composite opinion as to the proper diagnosis and treatment in all patients in whom neoplasms are suspected or observed. Such a Board usually acts in a consultative capacity in the case of inpatients, but may also serve as a definite treatment group in dealing with outpatients.

So much for activities of the active staff as a whole. Many other committees and similar groups can be formed as the need arises. A Journal Club, for example, in which members of the active, resident, and often consulting or associate staff cooperate in covering recent medical literature can be, if properly carried on, a great asset.

I have said nothing definite about departmentalization of the active staff. This is of course desirable in the larger hospitals with the various subspecialties represented as autonomous services, or as parts of the major divisions—medical and surgical. Each of these sections or services should have a chief, and their functions and sphere of activity should be clearly defined. They should have their own meetings and conferences and keep records of them.

One other matter should be considered: Consultations. The new Standard on this subject reads as follows: STANDARD—REQUIRED—II B 3

"Except in emergency, consultation with another qualified physician shall be required in all first Caesarean sections and in all curettages or other procedures by which a known or suspected pregnancy may be interrupted. The same requirement shall apply to operations performed for the sole purpose of sterilization on both male and female patients. Included in consultations required under this Standard are all those which are required under the rules of the hospital staff.

"In major surgical cases in which the patient is not a good risk, and in all cases in which the diagnosis is obscure, or when there is doubt as to the best therapeutic measures to be utilized, consultation is appropriate. Obviously, judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment rests with the physician responsible for the care of the patient. It is the duty of the hospital staff through its chiefs of service and executive committee to see that members of the staff do not fail in the matter of calling consultants as needed. A consultant must be well qualified to give an opinion in the field in which his opinion is sought.

"A satisfactory consultation includes examination of the patient and the record and a written opinion signed by the consultant, which is made part of the record. When operative procedures are involved, the consultation note, except in emergency, should be recorded prior to operation."

This Standard is believed to have met the criticisms leveled at the previous one which it replaces. Several of those who were most dissatisfied with the previous wording have expressed the opinion that it is now fully satisfactory. An explanatory note including a more complete definition of terms will be published in the BULLETIN OF THE COMMISSION, and elsewhere.

Of course, the active medical staff is but a part, albeit a most important part, of the medical team that runs the hospital. The nursing staff is another, and, in addition, we have social service, dietetics, engineering, etc.,—all of primary importance. For the proper organization and functioning of these divisions, adequate standards have been established; but these are beyond the scope of this communication as they are, for the most part, beyond the competence of the writer. Their excellence, as is the case with the medical staff, depends upon the basic quality of the people who run them. In general, it is the experience of the Joint Commission that hospitals are manned by superior people with high ideals and enthusiasm. The surveys show that throughout the country the work on the whole is being well done; and it is, for the most part, the duty and privilege of the commission to size up the situation in each hospital and to point out where improvement can be made in this detail or that. It is hard to imagine an instance in which, in such a complicated and detailed organization as a modern hospital, no chance for improvement can be found. The almost infinite number of details that should be considered is well illustrated in an article in HOSPITALS (Part II, June 1954) in which there are listed no less than 404 questions that can be asked of the administrator and staff in the process of investigating a hospital. (Of these, 115 pertain to the medical staff and 61 to medical records.) The encouraging fact is that in most instances in the development and functioning of the hospital under the supervision of clear-sighted, earnest trustees, a good administrator and a competent staff, these questions will—with very few exceptions—all have been answered correctly before they are asked.

This brings us back to the basic query and its answer, with which we began this discussion. The question is this: "What makes a good hospital?" The answer is "Good people."

CORRESPONDENCE ON CARBON DIOXIDE THERAPY ARTICLE

January 21, 1955

Dear Doctor Chase:

You published an article on Carbon Dioxide Therapy, by Laurence A. Senseman, M.D., in the July issue of the JOURNAL.

Lawrence Spielberger, M.D., in a letter written to the editor and published in the October issue, commented on Dr. Senseman's article and gave warning with respect to certain complications which might arise during the application of the carbon dioxide treatment, namely, and I quote:

"1. The stage of excitement with its high reflex irritability, particularly in the absence of premedication.

"2. Vomiting and aspiration.

"3. Respiratory obstruction."

Apparently, Dr. Spielberger has never used the carbon dioxide treatment himself and, therefore, his warning is justified on a hypothetical assumption. When experimenting with this somewhat novel method of treatment during the years 1943 through 1947, I had exactly the same misgivings and apprehensions—to the extent that during my experiments I requested the presence of an expert in resuscitation just in case any one of the above-mentioned complications might arise.

It took me four years of experimentation, during which I produced about 10,000 narcoses and anaesthesias by using a mixture of 30% carbon dioxide and 70% oxygen, to dispel my anxiety about such complications. Only after I became convinced that no vomiting and aspiration, nor respiratory obstruction or embarrassment, did occur during the four years of experimentation with the gas, did I publish the method in 1947. Since then, about 300 psychiatrists and quite a few general practitioners have been using the carbon dioxide treatment in this country. Furthermore, the method is used in France, Italy, Germany, Switzerland, England, Australia, Canada, South Africa, Japan and India. I would say, as a fair estimate, that over one-half million anaesthesias have been produced by using carbon dioxide in these countries as well as the United States and not one of Dr. Spielberger's complications have been reported. Therefore, we might state, with an almost 100% probability, that in spite of my own apprehensions and the justified warning of Dr. Spielberger, which is based on theoretical considerations, the practice, fortunately, has not borne out our assumptions. The method should, therefore, be considered to be safe in the hands of a properly trained physician.

I would greatly appreciate it if you would publish this letter in your JOURNAL.

Sincerely yours,

L. J. MEDUNA, M.D.
Professor of Psychiatry
University of Illinois College of Medicine,
Chicago 12, Illinois.

RECENT ADVANCES IN THE MANAGEMENT OF SEVERE AND EXTENSIVE BURNS

concluded from page 154

Other adjuncts in the treatment of burns are the recognized antibiotics, blood transfusions, plasma, high protein and carbohydrate diet with increase of vitamin intake. The most important complications of severe burns have been enumerated and briefly discussed.

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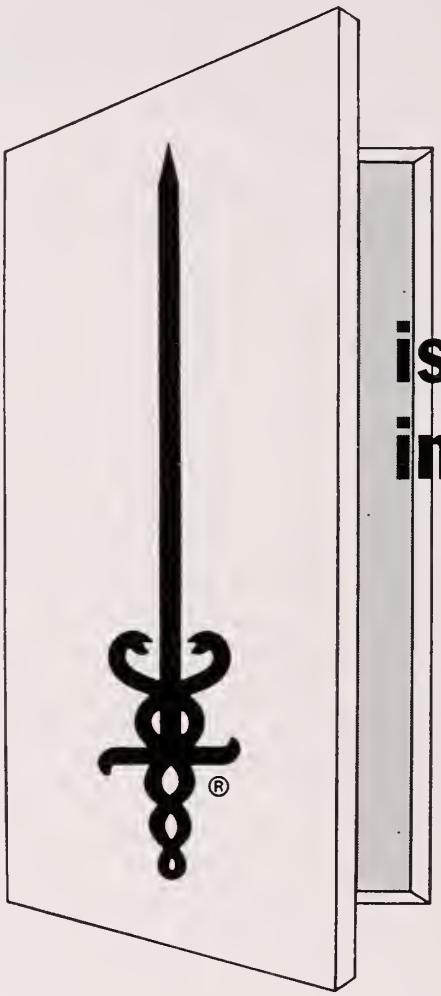
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1. Margolin, S., and Tislow, R.: Ann. Allergy *8*:515.
2. Rogers, H.L.: Ann. Allergy *12*:266.
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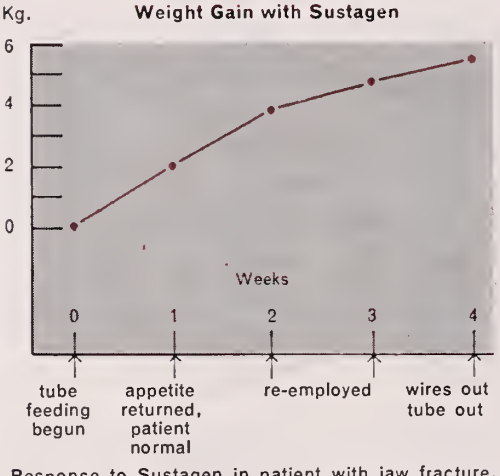
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†Therapeutic Nutrition, Publication No. 234, National Research Council.

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*Pareira, M. D.; Conrad, E. J.; Hicks, W., and Elman, R.: J.A.M.A. 156: 810, 1954.

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RHODE ISLAND MEDICAL JOURNAL

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144th ANNUAL MEETING of the Rhode Island Medical Society

See page 222

new reserpine therapy with control of nasal congestion

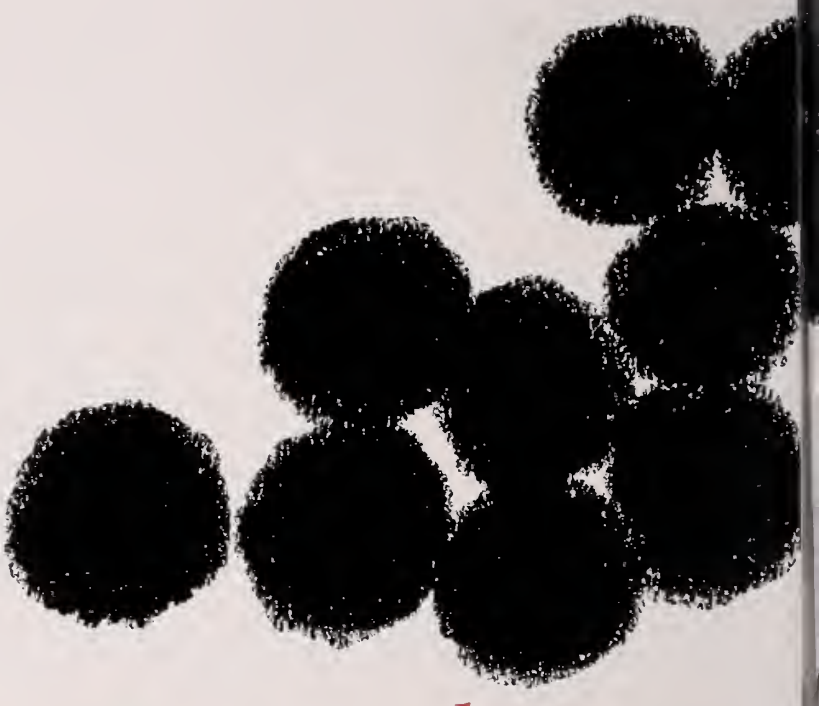
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*Pratt, R., & Dufrenoy, J.: Texas Rep. Biol. & Med. *12*:145, 1954.

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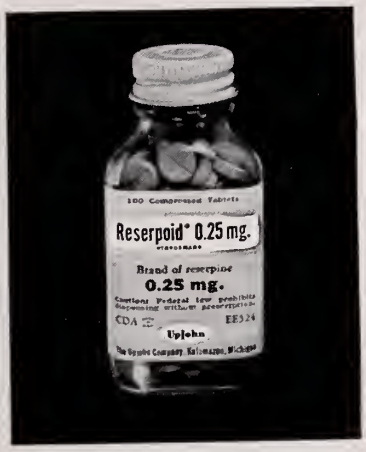
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1. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, Prepared with Collaboration of the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Baltimore, Waverly Press, 1952.

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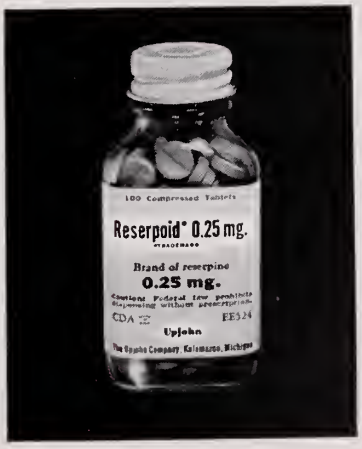
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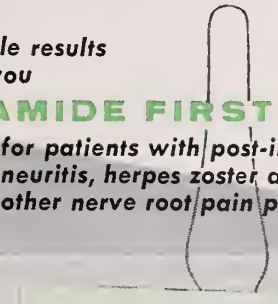
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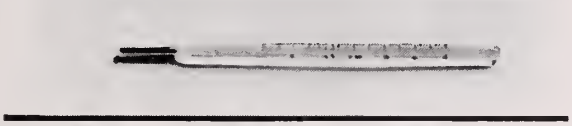
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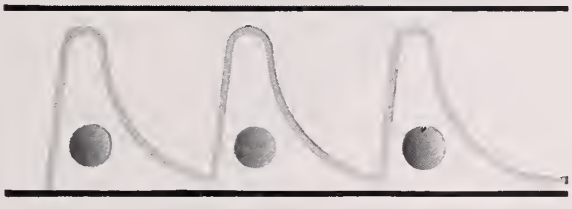
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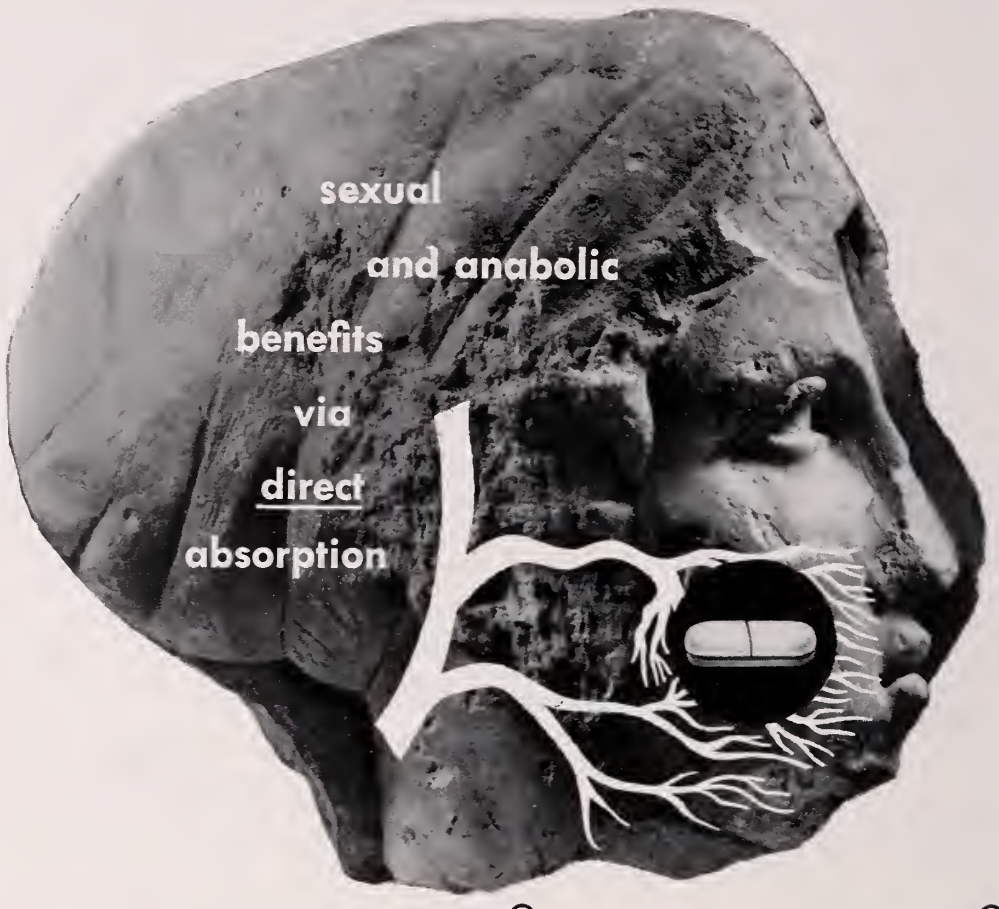
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXVIII APRIL, 1955 NO. 4

THE CLINICAL PROBLEM OF ASEPTIC MENINGITIS*

DEREK DENNY-BROWN, M.D.

The Author. *Derek Denny-Brown, M.D., of Boston, Massachusetts. James Jackson Putnam Professor of Neurology, Harvard University Medical School; Neurologist-in-Chief, Boston City Hospital.*

IN 1905, not long after he had first described the technique of lumbar puncture, Quincke described a series of cases he had encountered where the sole abnormality of the spinal fluid appeared to be an increase in pressure and in amount, the fluid itself remaining clear. This condition he called "serous meningitis," and described both acute and chronic types. The more chronic types were what we should now call chronic hydrocephalus. The most acute types were what we would now call "meningism" or the acute brain swelling associated with acute infections, and possibly some cases of what is now known as "otitic hydrocephalus." In the years since Quincke's observations similar acute often benign syndromes of meningeal irritation were recognized, differing from serous meningitis only in that a small increase in cellular content of the spinal fluid, usually lymphocytes, was often present. These also were called at first "meningitis serosa" on account of the lymphocytic cellular reactions, and were at first confused with tuberculous meningitis, or with lethargic encephalitis, or with abortive poliomyelitis. In 1925, Wallgren distinguished a group of cases of benign illness with headache, vomiting, fever and lymphocytic pleocytosis in the spinal fluid under the title "acute aseptic meningitis." It was not until 1934-35 that this disease was shown to be due to the virus of benign lymphocytic meningitis, which was isolated by Armstrong, Traub, Rivers and others. This condition is now generally known by that name. When the condition is severe up to 30 per cent polymorphonuclear cells may be present.[11]

Benign lymphocytic meningitis is, however, an uncommon disease, and many more cases of mild purely or predominantly lymphocytic reaction in the spinal fluid occur from other causes. Likewise, the failure to recover organisms from the spinal fluid, as suggested by Wallgren's word "aseptic," is sometimes found with quite severe cellular reactions in the spinal fluid. The term "aseptic meningitis" has therefore been used to cover a variety of conditions where the common denominator is an increase in cell content of the spinal fluid without the presence of organisms. This type of reaction in the spinal fluid is not uncommon in practice, and raises a number of problems. Such cases are still often labeled "meningism," "lymphocytic meningitis" or "meningo-encephalitis" or "tuberculous meningitis (unproven)," according to the severity of the illness, by those who are unaware of other possibilities.

In this paper it is proposed to discuss some of these possibilities, particularly in respect to some acute and dangerous illnesses the menace of which may be not recognized, or may be obscured by the above descriptive terms, until too late. In order to be sure of our facts we shall use chiefly postmortem material, for though we have seen many such cases recover, the actual cause often then remains a matter of opinion. Meningeal irritation whatever its cause and primary site, tends to give rise to the same symptoms and signs, namely headache, especially at the back of the head and high in the neck, nausea and vomiting, photophobia, neck rigidity, and spinal regidity, Kernig's and Brudzinski's signs when severe.

Of neck rigidity it is necessary to point out that simple limitation of the extent to which the head can be flexed forward on the chest is the most common finding. In its minor degrees this can be a very sensitive test. Unfortunately some do not admit the presence of the sign until a stage of board-like rigidity or even head retraction has been reached. This is only present with extreme degree of irritation.

A cellular reaction in the spinal fluid is provoked not only by an infection in or near the meninges, but by any foreign substance, by any superficial inflammatory reaction of the brain or spinal cord, or even by simple ischemic necrosis of brain if it

continued on next page

*Presented at the 108th Annual Meeting of the Providence Medical Association, at Providence, Rhode Island, January 3, 1955.

From the Neurological Unit, Boston City Hospital, and the Department of Neurology, Harvard Medical School.

is superficial enough. The definition of a "meningitis" from a "meningeal reaction" is therefore purely arbitrary. In general, if the primary cause of a patient's illness is an acute infection in the meningeal spaces one may expect 500 or more cells per cmm. in the spinal fluid, usually more than 1000. A spinal fluid containing only 50 to 200 cells for example indicates that any acute related symptoms are due either to some process near the meninges and not primarily in the subarachnoid space, or that the causitive infection of the meningeal spaces has already been walled off by adhesions and is not sampled by lumbar puncture. It is necessary to distinguish sharply between "meningitis" and "meningeal reaction" as a preliminary simplification of our problem. "Aseptic meningitis" for the purpose of this discussion, then, is meningeal irritation, without the presence of organisms demonstrable in smear or ordinary methods of culture. In this regard the level of sugar in the spinal fluid is of special significance, for the presence of organisms is almost universally associated with very low or absent sugar. The exact level of sugar is not important.

The nature of the cellular increase is of special significance. Normally the spinal fluid contains 1 or 2 lymphocytes per cmm. The presence of polymorphonuclear cells, even 1 per cmm., should immediately raise the possibility of either purulent or necrotic lesion. In general the more acute the process, the higher percentage of polymorphonuclears, and the presence of large mononuclears indicates a very chronic process, not necessarily tumor. In general also, virus diseases are associated with a lymphocytic response, but there are exceptions to this, and it is more accurate to say that since few virus diseases lead to massive necrosis a polymorphonuclear response is uncommon.

If the presence of polymorphs in the spinal fluid leads to the conclusion that necrosis is present, the severity of signs of neurological lesion in proportion to the severity of meningeal reaction then indicates whether the necrosis is primarily in the nervous system or in the meninges. Thus in simple cerebral thrombosis or embolism, pleocytosis may be confusing. For example, an eighty-one-year-old cardiac patient entered hospital with a two-day history of loss of speech, confusion, disorientation and mild neck rigidity, with temperature of 105°. The spinal fluid showed 20 rbc, 25 wbc, of which 8 were polymorphonuclears, 1+ Pandy, total protein 75 mg, no growth or culture. The diagnosis was cerebral embolism with meningitis, but autopsy following death from cardiac failure one week later showed only hemorrhagic infarction of the left occipital lobe without meningitis. There was pulmonary congestion, but no other cause of fever. A similar case with infarction of the cerebellar hemisphere showed a CSF pressure of over 300 mm., 3038 rbc and 120 wbc of which 88 were polymorphs, Pandy 2+, and reduction of sugar in second and following tubes. Following massive ischemic necrosis due to carotid occlusion we have seen as many as 2000 polymorphonuclears per cmm. in the spinal fluid for a few days.

In the beginning we mentioned otitic hydrocephalus or "serous meningitis" and differentiated it from "aseptic meningitis" because in the former the cell count in the spinal fluid is not changed. If, however, following otitis media or other sinus disease headache and papilledema are associated with a small cellular increase, up to 50 cells per cmm., and particularly if some of these are polymorphonuclear, in the absence of the dulling and neurological signs that predicate abscess formation, there should be suspicion of two possibilities. Either there is thrombosis of venous sinuses, producing an obstruction to absorption of fluid, and now extending to involve cerebral veins directly, and thus produce necrosis of brain, or an extradural abscess is commencing.

When an upper respiratory or throat infection has been followed within a few days by stupor, paralysis, cranial nerve signs, and a meningeal reaction, most physicians think first of brain abscess. But it is useful to remember that a brain abscess takes many days or weeks to form, and is usually preceded by a stage of invasion, in the form of mild meningeal irritation, headache and lethargy, without paralytic signs, during which the spinal fluid shows only a mild aseptic reaction. But there is a type of case where severe paralysis of one or both sides becomes the prominent feature from the earliest stage, associated with a spinal fluid cell count of up to 4000 polymorphonuclears, without organisms, and sugar of 50 to 60 mg per cent. In such a case the acute necrotizing hemorrhagic encephalopathy described by Adams, Cammermeyer and myself[2] is likely. It is a type of hypersensitivity reaction in the brain, without organisms, yet is precipitated by an infection such as a streptococcal sore throat, and may be rapidly fatal.

The next most dangerous complication of acute sinus infection, without actual meningitis, is subdural empyema. This is an unusual happening and in my own experience most commonly associated with fulminating frontal sinus disease. Some puffiness of the related orbit is then often an external sign of the frontal osteitis. Drowsiness, stupor, hemiparesis and meningeal reaction then document the introcranial extension. Recently, for example, a fifteen-year-old boy, P. G., developed a sudden severe frontal headache, and several hours later a bout of vomiting. On the second day the headache persisted, with intermittent vomiting, and a shaking chill, and these continued. On the fourth day

the physician was called, gave him penicillin, and sent him to hospital, where he arrived having just had a generalized convulsion, followed by coma. His previous health was non-contributory, except possibly a history of pleurisy at the age of four years. His temperature was then 105°. There were petechiae on the neck, anterior chest, and arms. The ears appeared healthy, the posterior pharynx was infected with purulent streaks. He could respond to simple commands but was stuporous. There was marked neck rigidity, hypoactive reflexes and right extensor plantar response, but no cranial nerve signs and only slight weakness of the right limbs. There was a leucocytosis of 12,250 and lumbar puncture showed an initial pressure of 350 mm., with cloudy fluid containing 480 cells, 99 percent polymorphs, 1+ Pandy, total protein 114, sugar 87 mg, sterile culture. He was treated with penicillin i.v. and sulfadiazine, with fall in temperature to 101.6°, but there was no change in signs. On the third hospital day he suddenly became unresponsive and developed dilated pupils and irregular respiration, and died before surgical intervention could be undertaken. Autopsy showed purulent frontal sinusitis with massive left subdural abscess, due to staphylococcus aureus. The catastrophic fulminating illness in this case was obscured by the entire absence of external signs of the frontal sinusitis. The spinal fluid reaction was separated from the abscess by the arachnoid membrane. In reporting twelve such cases, Kubik and Adams[6] found cell counts ranging from 15 to over 900, predominantly polymorphonuclear with normal sugar and sterile fluid. Since this condition can be treated successfully by surgical drainage if recognized early enough it is important to bear in mind.

In young children the most disturbing possibility of this kind is lead encephalopathy which is commonly associated with a mild pleocytosis in the spinal fluid. For example, a twenty-month-old child was admitted with a history of a cold two weeks before admission, followed by increasing irritability leading up to vomiting and a series of convulsions two days before admission. Frequent convulsions associated with twitchings of isolated muscles continued after admission. The spinal fluid showed an initial cell count of 58 cells of which 21 were polymorphonuclears, and on later days the cell counts rose at times to as high as 137. The child eventually succumbed to a severe lead encephalopathy on the thirteenth day.[5]

The types of cases I have just discussed are remarkable for the brief duration of illness. To contrast these with typical brain abscess I might summarize the case of a middle-aged man who had a chronic cough for two years, production of copius amounts of sputum, and two episodes of hemoptysis. For three weeks he had had severe bifrontal headaches, had been mentally dull. He had occasional low fever, showed mild cerebellar signs, early papilledema, and bilateral extensor plantar responses. There was bronchiectasis. The spinal fluid showed a pressure of 320 mm. and contained 101 cells, 17 per cent polymorphs, total protein 91 mg., sugar 90 mg., and chlorides of 717 mg., with negative smear and culture. After many vicissitudes of treatment he eventully succumbed to the effects of a cerebellar abscess. In that story you will note the early clinical evidence of brain lesion, and the much slower evolution of meningeal signs, compared with hemorrhagic necrotizing encephalopathy or subdural abscess.

Another type of aseptic reaction with primary brain damage not uncommonly observed by us, and seldom seriously considered in differential diagnosis is the metastatic disorder of subacute bacterial endocarditis. Thus a man with a history of heart murmur for some years, developed a "cold" with earache and generalized weakness one week prior to admission and developed severe headache on the fourth day of illness and that evening became irrational in behavior and speech. The next morning he was found to have fallen from his bed, unable to rise because of right hemiplegia. On admission he had a temperature of 102°, was completely disoriented and unable to speak coherently, and had a severe right hemiplegia. He had soft systolic and diastolic murmurs in the aortic area and pistol shot murmurs in both arms. There was neck stiffness and positive Brudzinski. The CSF showed pressure 480 mm., 495 lymphocytes, Pandy ++, culture negative. He was treated with penicillin and the third hospital day the spinal fluid showed 20 lymphocytes, 140 polymorphs, and 80 rbc per cmm., sugar 63, total protein 54, chlorides 692. Repeated CSF and blood cultures were negative. Under treatment the CSF cell count dropped to 24 lymphocytes and 0 polys on 35th day. He eventually recovered with a mild residual hemiplegia, but two months later he had a seizure, and then many more, in the course of which he succumbed. Autopsy showed a healing infarct in the left internal capsule, and a fresh mycotic aneurysm with hemorrhage in the right parietal lobe, from subacute bacterial endocarditis.

The remaining acute emergency with aseptic meningeal reaction is acute epidural spinal abscess. A history of backache for some days, with root pains, followed by weakness and sensory loss in the lower limbs, associated with meningeal signs, is typical. Twenty to 700 cells in a sterile spinal fluid and a high protein may be expected. Heusner[3] has analyzed a group of such cases observed in Boston City Hospital. The abscess may be from ostomyelitis of the spine, or a metastatis in the

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epidural fat from chronic staphlycoccal infection. A critical degree of spinal symptoms develops in from five to thirty days and is a true surgical emergency, for unless relieved the abscess creates irreversible damage to spinal cord.

The acute virus infections of the nervous system are all associated with a cellular response in the spinal fluid. This is so whether the disorder is a simple herpes, affecting only one or two nerve roots, is a diffuse encephalopathy such as lethargic or equine or Japanese B encephalitis, or is primarily meningeal as is benign lymphocytic meningitis. Of course the extent of damage to tissue determines the severity of the reaction, but many diagnostic errors will be avoided if the term "encephalitis" is not used unless there is a spinal fluid pleocytosis. Drowsiness is still popularly associated with lethargic encephalitis, but it cannot be too strongly emphasized that drowsiness is associated with any type of diffuse impairment of brain function. Drowsiness without meningeal reaction should lead first to suspicion of acute hydrocephalus, caused probably by brain tumor. Drowsiness with meningeal reaction is caused most commonly by oncoming tuberculous meningitis. In encephalitis, however, the disturbance of vital signs as well as the disorder of awareness appear out of all proportion to the mild meningeal reaction. The virus infections are all acute diseases. You will all be acquainted with the meningeal stage of poliomyelitis, but few realize how similar is the reaction to infection by Coxsackie virus, or by mumps, or even measles.

The Coxsackie group of viruses are grouped into two types A and B, of which group A causes herpangina, and group B usually causes epidemic pleurodynia (Bornholm disease). Recently, however, type B virus has been recovered by Melnick and associates, and others,[7,4] from patients suffering from an illness characterized by headache, stiff neck, and backache, in addition to symmetrical myalgia, low fever, malaise and nausea. All patients presented meningeal signs, and cellular increase in the spinal fluid running from 22 to 99 cells in the spinal fluid (up to 40 per cent polymorphs), with globulin + to ++. The fever lasted three to ten days, there was no paralysis, and the muscle pains had disappeared within two weeks. This type of illness differs from the usually mild type of meningitis seen with mumps only in the appearance of polymorphonuclears, and in the prominence of muscular aching and tenderness.

Another type of epidemic clinical signs suggesting meningeal reaction with more puzzling features has appeared in many places since 1949. This is "Iceland disease," first described in Iceland in the winter 1948-49,[9] in Australia in 1949 and 1950,[8] in New York State in the late summer of 1950,[12] and in England in 1952.[1] This illness also begins with low grade fever, pain in the neck, and severe muscular pain, but in addition there was numbness, pain and tingling in the limbs and muscular weakness. The illness is unlike poliomyelitis because it tends to occur in winter months, there is no muscular wasting, and loss of sensation and even pyramidal signs may be present. In most of the cases described, the spinal fluid has been normal throughout, but in a few a very small increase in lymphocytes (2 to 8 cells) has been found in an early stage. Finally muscular tenderness in quite large groups of muscles has been commonly present for many months. In most cases neither poliomyelitis nor Coxsackie virus nor their antibodies could be found. In only one case was a poliomyelitis type 3 virus recovered from the stools, and this may have been a coincidence. The cause of Iceland disease is unknown. You will note that the spinal fluid is usually normal, and thus I suspect it is not a nervous system virus infection at all. The following case appears to me to be pertinent: A student nurse age 19 developed a stiff neck one morning in October 1952, with a low fever. The stiffness extended down the back in the following day. The spinal fluid showed no change. After a week of severe neck pain and rigidity, weakness of the right hand and forearm and both thighs developed, with paresthesias and mild loss of sensation in the right hand and left foot, with 4 lymphocytes, a positive Pandy, and protein of 43 mg. per cent in the spinal fluid. The white count in the blood remained around 9,050, with normal sed. rate and X rays of spine. The weakness and senory changes disappeared after five days but the muscular aching in the neck and mid-dorsal region continued for the next eight months in spite of varied treatments. At that time, when I saw her, there was aching in the upper dorsal spine, and back of the neck, radiating into the arms after exercise, and worse when attempting to bend forward. There were no abnormal neurological signs, but the whole upper dorsal spine was held as rigid as a board. The spinous process of C_6 was a little tender. Careful x-rays of the spine showed a blurring of the posterior intervertebral joints in the region C_5 to about D_4 and finally established the presence of a mild, chronic spondylitis in this region. This has since responded completely to treatment and she was entirely recovered and back at work one year after the onset. Brucella infection was supected, but agglutination was within normal limits when I saw her. The lesson of this case is that arthritis of the cervical spine in a young person, can closely mimic epidemic myalgia. Another similar nonviral disorder in this category is acute leptospirosis. In a recent case seen by my associate, Dr. Foley, the spinal fluid cell count was 98 lymphocytes at the height of the illness. The liver and myocardial damage should lead to suspicion of this cause.

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BILATERAL ADRENALECTOMY AND OOPHORECTOMY IN THE TREATMENT OF RECURRENT CARCINOMA OF THE BREAST*

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BREAST MALIGNANCY accounts for approximately 17% of deaths in females from carcinoma in a given year, and this ranks second to cancer of the digestive organs, and essentially on a par with carcinoma of the uterus, as a leading cause of death from cancer.

Over the years, surgery and x-ray radiation have been the bulwarks of treatment. Certain tumors of the breast are thought to be hormone sustained, influenced either by androgens or estrogens as the case may be. Beatson,[1] in 1896, observed regression in two cases of breast malignancy following bilateral oophorectomy. Lett,[2] in 1905, analyzed 99 cases of inoperable carcinoma of the breast treated by oophorectomy, showing that 36% were improved. Following this work, the procedure received scant attention in the literature for many years, probably because of the fact that ovarian irradiation came to the fore as a method of therapy. In recent years, numerous studies have been performed on laboratory animals to determine the part played by hormones in the development and sustenance of tumors. Prostatic cancer and recurrent carcinoma of the breast have received the most attention. Breast tumors have been created in rats and the influence of such procedures as bilateral oophorectomy, bilateral adrenalectomy, hypothecectomy and a combination of any or all of these procedures has been studied as to their effect upon these tumors. A measurement of the 17 Keto steroids in the urine has served as an indication of hormonal activity in the animals or humans under investigation. The normal or premenopausal human female excretes anywhere between 60 and 40 international units, the postmenopausal female between 40 and 30 international units, the bilaterally oophorectomized female between 30 and 10 units, and when bilateral adrenalectomy is added to oophorectomy, 0 units. Experimental work upon animals has indicated the value of this procedure and has led the way to clinical investigation with human patients suffering from recurrent carcinoma of the breast.

Huggins,[3] in 1951, performed the first bilateral adrenalectomy and oophorectomy for recurrent carcinoma of the breast. In June, 1954, at an exhibit of the American Medical Association in San Francisco, it was indicated that this patient was still alive.

Randall[4] of the New York Memorial Hospital for Cancer feels adrenalectomy may be considered as a possible additional means of temporary control of advanced breast cancer, particularly in cases which have shown a response to castration. Huggins[3] feels that all patients undergoing operation for carcinoma of the breast should then, or in a short period of time thereafter, undergo bilateral oophorectomy because of the known influence of these glands upon the life of many such tumors. This is a prophylactic step. When definite metastasis occurs, bilateral adrenalectomy is then performed. The New York Memorial group advise castration once metastases have manifested themselves in the premenopausal patients, and, if the results are favorable, bilateral adrenalectomy is then added. In the postmenopausal group of patients developing metastatic lesions, bilateral adrenalectomy and oophorectomy is performed. It is generally agreed that approximately 40% of such patients undergo significant palliation. Taylor[5] reported upon eleven patients treated with Cortisone alone and not adrenalectomitized, stating they did not receive the same amount of palliation as those who were. Numerous authors agree that there is no method known for predicting which patients may be expected to respond favorably. Patients under the age of forty have a grave prognosis. The longer the interval between original mastectomy and recurrence, the better the prognosis. Patients with onset of metastases in less than one year following mastectomy rarely respond to adrenalectomy. Inflammatory carcinoma suggests a poor outlook. Women excreting high estrogen titers in urine respond better to adrenalectomy than those who excrete small amounts. Galante[6] points out that in patients who have failed to respond to established methods of

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therapy, bilateral oophorectomy and adrenalectomy appear to offer an additional therapeutic step. He cites a 22% objective improvement and a 45% subjective benefit.

Total adrenalectomy, with or without concomitant oophorectomy, has been performed by us upon eight patients since October, 1953, and constitutes the basis for this report. Of these eight, seven were operated upon prior to January, 1954, and have a sufficiently long follow-up to make the analysis significant. Of the seven patients under consideration, two are now dead, five are living. All of these patients were selected for treatment on the basis of widespread metastatic disease, some had previously undergone x-ray therapy, and hormonal therapy, or both.

A brief summary of their case histories follows.

Case No. 1: (L.K.) The patient was a forty-seven-year-old female who underwent left radical mastectomy for adenocarcinoma of breast with axillary metastases in September, 1950. X-ray therapy followed. In June, 1951, she first showed signs suggesting recurrence, i.e., pain in right lower lateral and anterior chest making breathing difficult. X-ray studies revealed metastatic involvement of ribs on right side, lumbar spine, and sacrum, and possibly upper ends of both femora. Testosterone therapy was started, 100 mgs. three times weekly. This seemed to help for a time, patient feeling better and gaining fourteen pounds in weight. Abdominal hysterectomy and bilateral salpingo-oophorectomy performed in December, 1951. Testosterone continued. Patient bedridden in July, 1953, having intermittent attacks of pain. Bilateral adrenalectomy performed October, 1953. Operation gave a short subjective relief for approximately six weeks. Patient then gradually went downhill, succumbing February 23d, 1954, after a final painful hospitalization period of four to six weeks.

Case No. 2: (H.S.) This thirty-five-year-old female was operated upon elsewhere February, 1952, for carcinoma of right breast with metastases. First seen in August, 1952, because of small nodules, noted by her, in right axilla. Examination also revealed numerous nodules in right supraclavicular and lateral neck region. X-ray studies of chest and lumbar spine essentially negative. Bilateral oophorectomy performed August 28th, 1952. X-ray therapy started soon thereafter. Nodules disappeared, appetite returned, aches and pains departed. In September, 1953, began with "terrible backache" going down legs and into knees. Appetite poor. Lost nine pounds in weight. Some small nodules felt in skin of right neck. Biopsy revealed recurrent carcinoma subcutaneously with a metastatic lymph node. Bilateral total adrenalectomy performed in November, 1953. On first visit to office postoperatively, looked pale, was somewhat edematous. Liver down four fingers. Some fluid grade 2 plus in abdominal cavity. Had small petechial hemorrhages skin of left forearm. Nodules could be felt around shoulders and right upper arm. About a week later family physician called to state patient was more or less in coma, and he felt it was a liver coma, not due to adrenal insufficiency. Hospitalization refused. Patient succumbed in a few days.

Case No. 3: (M.L.) This sixty-year-old white female had a lump in right breast 3½ to 4 months. Right radical mastectomy for adenocarcinoma of breast with metastases to axillary lymph nodes performed October, 1952. Patient did well for one year, being seen regularly. Some suspicious small nodules were felt in both neck regions in November, 1953. Metastatic x-ray series revealed advanced generalized bone productive metastases throughout skull, complete spine and pelvis, as well as both shoulder girdles and ribs, undoubtedly related to carcinoma right breast. Bilateral adrenalectomy and oophorectomy performed in December, 1953. Course since then to date has been splendid, patient feeling finely, working and carrying on as if nothing were wrong. Repeat x-ray studies in June, 1954, suggested healing of lesions. Urinary calcium low, 5 to 7½ mg. per 100cc suggesting bone destruction not going on. Last seen October, 1954, weight 154, B.P. 148/98, feeling perfectly well.

Case No. 4: (A.B.) This forty-eight-year-old female underwent right radical mastectomy in 1948. Since August, 1952, has been troubled with sacroiliac backache off and on, gradually getting more severe, so that for the past three months has been practically confined to bed, getting only into chair occasionally. Backache radiates down leg so she is unable to walk correctly. Patient jaundiced, icteric, weighing 82 pounds, liver edge felt four fingers below right costal margin. X rays revealed the presence of metastatic lesions in the spine and ribs. Bilateral oophorectomy and bilateral adrenalectomy performed December, 1953. Since operation patient has gained steadily except for one short bout of adrenal insufficiency in August, 1954. She has gained 35 pounds in weight, maintained a normal blood pressure and pulse. Her jaundice has disappeared. Liver edge can barely be felt, and in all respects she feels cured and lives a normal life.

Case No. 5: (C.R.) This fifty-nine-year-old female underwent left radical mastectomy for adenocarcinoma in June, 1953. Now, December, 1953, she has metastases in her chest and comes in for total adrenalectomy. Bilateral total adrenalectomy and oophorectomy performed. This patient has done well. Very dyspneic before operation, in bed most of time. No pain on coughing now, and

cough has practically disappeared. Sleeping with one pillow. Family sees great improvement. Has gained 20 pounds in weight. B.P. normal. Is up and about, leading a fairly normal life when last seen October, 1954.

Case No. 6: (B.V.) This forty-three-year-old white female underwent a left radical mastectomy in March, 1950, for adenocarcinoma of breast without metastases. In May, 1950, developed some slight swelling of left arm, including hand and fingers. In December, 1950, left arm was somewhat firm and indurated, had complete motion. Thought to be seat of venous vascular occlusion with some swelling. In September, 1953, patient began with considerable swelling of left arm and hand, pain in wrist and numbness which wakened her at night. X-ray studies revealed metastatic neoplasm involving good portion of dorsal spine and sternum, possibly also some of ribs on right side. Patient put on testosterone 100 mgs. TID. Bilateral total adrenalectomy and oophorectomy performed in December, 1953. At office in January, 1953, stated she was feeling finely, ironed clothes and baked a cake. Left arm is fine and doesn't bother her at all. Last seen October, 1954, feeling finely, working as dietitian's helper days, running cider press nights.

Case No. 7: (A.G.) This forty-two-year-old female underwent left radical mastectomy in June, 1951. She did well until April, 1953, when she complained of slight pain in her back. A sacroiliac belt was ordered, without help. In December, 1953, she was x-rayed and metastatic carcinoma of fifth lumbar vertebrae diagnosed. Left oophorectomy, bilateral adrenalectomy performed on January 2, 1954. This patient has had a fair result thus far, but not an ideal one. Her pain was relieved for a while, only to return. She was put on increased doses of cortisone and testosterone, gaining considerable weight, having quite some pain. With discontinuance of testosterone she has improved. She takes Emagrin tablets twice daily and has no pain whatsoever. Is sleeping well with help. Appetite is good. Does all her own housework and takes care of children.

Summarizing our results in this group of seven cases, followed for a period of about one year, two are now dead and showed no significant response to the therapy, a mortality and failure rate of 29%. Four have improved markedly and are leading essentially normal lives, a 58% favorable response. One has improved moderately, leading a somewhat restricted but still painless existence, and can be said to have been significantly palliated, if not completely so. There has been no operative mortality in this group.

The pre-operative preparation of these patients for surgery and their postoperative management are most important. The average patient who can withstand a major surgical procedure can also withstand bilateral oophorectomy and adrenalectomy. In addition to the usual preoperative preparation for major surgery, such a patient is given 50 mgs. of cortisone I.M. every six hours, the day before operation, including 5 mgs. of DOCA I.M. and 5 grams of added salt to the diet. The morning of the operation another 50 mgs. of cortisone and 5 mgs. of DOCA are administered. During the operative procedure 1000cc. of blood is given, and if necessary, the blood pressure is supported by injection of norepinephrine. The first twenty-four hours postoperatively the patient receives 50 mgs. of cortisone I.M. every six hours, and one injection of 5 mgs. of DOCA. The second twenty-four hours cortisone is given I.M., 50 mgs. every eight hours, with 5 mgs. of DOCA. The third twenty-four hours cortisone is given I.M. 50 mgs. every twelve hours, with DOCA 3 mgs. On the fourth day cortisone may be given by mouth, 25 mgs. every six hours and DOCA thereafter 3 mgs. every other day. Cortisone is promptly cut down to a basal dose of 25 mgs. BID. Added salt to the diet is given — approximately 3 grams daily. These patients appear no more difficult to handle postoperatively than the average severe diabetic. They are informed about their state and instructed to consult a physician in the case of any sudden unexpected stress which may change their metabolic requirements. Malaise, weakness, orthostatic hypotension, sweating, tachycardia — all may suggest impending adrenal crisis and should be promptly recognized and treated.

The operation itself consumes approximately two hours. The adrenal glands are removed with the patient in the posterolateral position, resecting the twelfth rib. We have removed the ovaries in the turn-over of the patient from one side to the other when this has been necessary. The severely ill patients withstand the procedure remarkably well, and the results have been most gratifying to date.

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THE PROBLEM OF PLATELET TRANSFUSION

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GREAT STRIDES have been made in the use and availability of whole blood transfusions. In the last quarter century, it has been recognized that the infusion of blood stored in ACD ("citrate") solution is capable of replenishing blood volume and red cells. As to the blood platelets, very few published attempts to transfuse them exist prior to 1950. In 1947, Lawrence and Valentine reported that massive direct transfusions of whole blood without anticoagulants did not result in a rise of platelets in the recipient.[1] On the other hand, direct vascular anastomosis in animals made platelet transfer possible.[2] In 1948, when the coating of glass surfaces with silicon and the clot delaying action of such coated glass was first reported, Hirsch and Dameshek were able to achieve a successful transfusion of platelets by transferring blood from a polycythemic donor with high platelet count into a thrombocytopenic recipient by means of silicon coated syringes.[3] Subsequently the systematic use of high platelet polycythemic donors and the use of silicon coated syringes made possible an evaluation of platelet transfusions into thrombocytopenic recipients.[4]

The following conclusions were arrived at:[4,5]

1. In patients with aplastic anemia, donor platelets can be recovered almost quantitatively. Their life span is between five and six days.

2. In idiopathic thrombocytopenic purpura, the life span of transfused platelets is shortened, varying between a few hours to three days.

3. Repeated transfusions of blood containing intact platelets results in a successive decrease in platelet recovery and survival.

4. The bleeding tendency of the recipient is brought under control whenever a rise in platelet count, however short, can be produced in the recipient. Clinical improvement frequently outlasts platelet survival but the *tendency* to bleed as distinct from actual bleeding closely parallels platelet survival.

Before discussing further progress in the technique of platelet transfusion, it is well to remember some basic problems.

Bleeding due to thrombocytopenia only occurs when the platelet count is below 40,000 per cubic mm. Usually at a time when platelet transfusion appears desirable, the platelet count is 10,000 or less. The average normal platelet count is around 250,000. An adult male with a blood volume of 5,000 liters would therefore require 1/5 of his blood volume to raise his platelet count from 0 to 50,000. This would involve the rapid infusion of 1,000 c.c.'s of blood, which is impractical unless the patient is severely anemic and the possessor of a strong cardiovascular system. Moreover this would meet only minimum requirements and would assume that all platelets have actually reached him in a viable state. In order to allow for a margin of safety, 1,500 c.c.'s of blood are necessary. It is for this reason that patients with polycythemia vera who possess high platelet counts (not all do) make the best donors when a platelet transfusion is desired. If the donor has a platelet count of 750,000, then 500 c.c.'s of his blood would raise the platelet count of the recipient by 75,000.

Progress in Techniques

The use of siliconed syringes while possessing some advantages requires siliconizing of equipment. Results equally good as those observed with siliconed syringes were obtained with plastic containers, each holding 125 c.c.'s. These plastic containers are furnished with suitable outlets and contain no anticoagulants. The donor and the recipient are placed nearby. Arquad coated needles are introduced into a vein of each, a plastic bag is attached to the needle in the donor's vein and when full, it is transferred to the recipient. In the meanwhile, donor blood is collected in another plastic container. These are discarded after use.

Recent studies indicate that platelets remain intact if blood is collected in plastic containers containing ethylene-diamine-tetra-acetate (EDTA) as an anticoagulant. This makes it possible to collect 500 c.c.'s at one time and allows somewhat more time to elapse between blood collection and infusion. It does not obviate the use of high platelet polycythemic donors.

In an attempt to avoid the use of polycythemic donors, attempts have been made to concentrate platelets from normal donors in a small volume.[6] The evidence strongly suggests that by the use of EDTA as an anticoagulant, platelets can be concentrated, and when infused survive normally. It must be realized however that the preparation of platelet concentrates is time consuming, requires extreme care, and the use of refrigerated centrifuges.

For the time being, therefore, the use of polycythemic donors is still essential.

Successful platelet transfusion therefor can today only be made available by the use of specialized equipment, meticulous technique, expeditious handling of blood to be transfused and the availability of a panel of polycythemic high-platelet donors. The following two cases illustrate the benefits derived from platelet transfusion and the advantage of having polycythemic donors available.

Case 1. W. C., a nineteen-year-old, white, male has had acute lymphatic leukemia since April, 1954. Cortisone produced a partial remission, but in September, 1954, when his platelet count fell to almost zero, uncontrollable bleeding from the nose developed. After contacting several physicians and institutions in the Providence area, a suitable polycythemic donor with a platelet count of 600,000 was found through the courtesy of Dr. Irving Beck. A semi-direct transfusion of 500 c.c.'s of this donor's blood was given utilizing 250 c.c. plastic containers without anticoagulants. Although ten minutes after transfusion the platelet count had risen to only 25,000, bleeding stopped and has not recurred since. Although the platelet count remained low for another six weeks, at the end of that time a rise in platelet count occurred due to a remission under 6-mercaptopurin therapy. *Comment:* In this patient with acute leukemia, it was possible to arrest a troublesome hemorrhage and tide the patient over until a remission had occurred. Had a polycythemic donor not been made available and had the technique of platelet transfusion not existed, the bleeding would at least have been the cause of prolonged hospitalization. As it was, cessation of hemorrhage added greatly to the comfort and optimism of the patient.

Case 2. P. S., a seven-year-old, white, girl had had aplastic anemia for five months. When I was first asked to see her, bleeding from the nose had been very troublesome for several days and had failed to respond to conventional methods of treatment. Again a search for a suitable polycythemic donor was made and one was discovered at the Howard State Hospital through the courtesy of the administration, the physicians, and the laboratory technicians at the State Hospital. Six hundred c.c.'s of the donor's blood was collected in a plastic container containing ethylene-diamine-tetra-acetate as the only anticoagulant. The container was immediately placed in ice water, taken to the bedside of the patient, and infusion started approximately one and one-half hours after the blood had been drawn. There was a fairly severe histamine-like reaction but the platelet count rose from practically zero to 90,000 and remained at this level for two days. The reaction and the rapid disappearance of infused platelets must be blamed on the patient's sensitization to platelets caused by previous transfusions. These reactions are common in such individuals but are not dangerous and can probably be controlled by the antihistamines and adrenalin. In this patient, bleeding from the nose stopped dramatically during infusion of the platelet-rich blood and did not reoccur for several weeks. *Comment:* This is another instance where through the cooperation of other institutions a polycythemic donor was made available and in which his blood aided greatly in adding to the comfort of the patient and in her management.

CONCLUSION

Platelet transfusions from polycythemic donors is a practical method of therapy in cases of thrombocytopenia. It is preferable to special concentrating techniques which are excessively time consuming. In order to enable the use of platelet transfusions from people with polycythemia vera, it would be desirable to have a panel of such people with a record of their blood types and platelet count in the blood banks of the state. These people could then be contacted expeditiously, when there is need for a platelet transfusion.

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PATRONIZE JOURNAL ADVERTISERS

RUPTURED LUMBAR INTERVERTEBRAL DISK SYNDROME CAUSED BY METASTATIC DISEASE

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NOWADAYS the excision of a ruptured lumbar intervertebral disk is an exceedingly common operation. Operative mortality is generally less than 1%, and the lesion benign. So the patient complaining of low back pain and sciatica — "the ruptured intervertebral disk syndrome" — gets a good prognosis. Because the possibility of a malignant disk lesion is rarely mentioned, this case is reported.

Case Report: A.B.* a white woman of 57, in January, 1954, first complained of right sciatica. By March, 1954, the pain lessened but never disappeared. It recurred with severity in May, 1954; she spent sleepless nights because of pain; movements of any kind aggravated it. No disturbances of urination. Weight loss of about ten pounds in six months.

In 1934, she had a total hysterectomy and oophorectomy; no malignancy was noted.

Examination: Patient could hardly stand because of sharp, jabbing pain in the right hip. Straight-leg-raising was painful on the right at fifty degrees, on the left at eighty. Sensation to pinprick diminished over right first sacral dermatome. Good strength and tone in the lower limbs. The ankle and knee reflexes were absent. Rectal examination was negative. No masses could be palpated in the breasts. Thyroid gland was not enlarged.

Laboratory: Roentgenograms of the lumbosacral region and chest showed no gross abnormalities. A tiny area of radiolucency in the right iliac crest was reported normal by several roentgenologists. Pantopaque myelography outlined a concave deformity extending from the lower portion of the L5 vertebra to the first sacral. This was interpreted as a large intervertebral disk protrusion or possibly a neoplasm. Cerebrospinal fluid contained 200 mg.% protein.

Operation: On 3 June, 1954, a bilateral lumbosacral laminectomy was done. On exposing the sacrum on the right side, a thinned out area of bone 5 mm. in diameter was seen. The laminae were extremely thin and papery when removed by a rongeur. Presenting between the first sacral nerve root and the common dural sac medially, the mass was covered with posterior longitudinal ligament and apparently coming from the intervertebral disk space. With a blunt instrument the mass was easily opened; it contained soft necrotic material. The disk space was completely empty except for a few tiny fragments of similar material. Frozen section of this material revealed giant cells but no evidence of neoplastic disease. The posterior-inferior portion of the body of the L5 vertebra was friable and apparently eroded. The laminectomy was carried over to the left side, and after retraction of the left first sacral nerve root and common dural sac, the posterior longitudinal ligament was here, too, soft and the disk space was emptied of further necrotic material.

Pathological report: Metastatic papillary adenocarcinoma. Microscopic sections showed, "a papillary pattern of branching and coalescing connective tissue processes which are covered with multilayered polygonal and polyhedral cells containing large pleomorphic bizarre-shaped hyperchromatic nuclei. Glandular spaces are formed by agglutination of the papillary processes. Many spicules of necrosed, destroyed bone are incorporated in the growth." (Figure I)

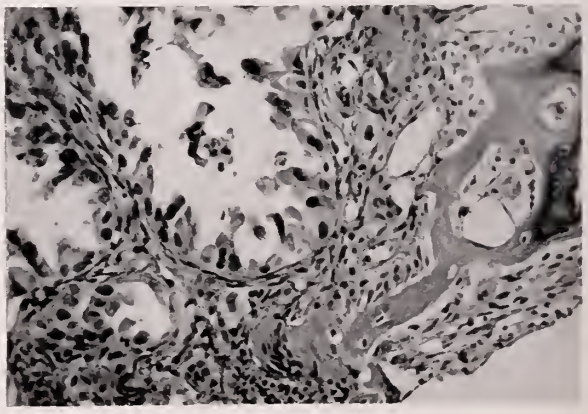


FIGURE I

Microphotograph of metastatic adenocarcinoma to the intervertebral disk. Note necrosed bone spicules. (x200)

*Patient referred by James Hardiman, M.D., Providence.

Course: Patient was relieved of the sharp pain in the right lower limb, but complained of an aching sensation behind both knees. On the tenth postoperative day she was out of bed, but unable to walk unassisted. Though able to control her bladder and bowels, there was bilateral weakness of dorsiflexion of the feet.

An unsuccessful search was made for a primary neoplasm in the breast, thyroid, gastrointestinal and genitourinary systems.

Patient is alive and comfortable six months after laminectomy and one year after onset of symptoms.

Comment

While metastases to the lumbar vertebrae from thyroid, prostate and breast malignancies are relatively common, those to the intervertebral disks are practically unheard of, perhaps owing to the poor blood supply of the intervertebral disk. The presence of necrotic bone in the pathological specimen would favor metastases to vertebral body with extension to the intervertebral disk. The erosion noted at operation was not more than several millimeters. Even postoperative roentgenograms of the lumbar spine failed to show a lesion of the vertebral body. It seems probable that the metastasis was chiefly to the intervertebral disk though it cannot be proved.

SUMMARY

Laminectomy for ruptured lumbar intervertebral disk perhaps offers the best prognosis of all neurosurgical operations. Yet metastases to lumbar intervertebral disk can simulate a benign disk lesion as proved by this case of a 57-year-old woman with typical signs and symptoms of a ruptured L5 disk, who had metastatic adenocarcinoma to the L5 disk.

ACKNOWLEDGMENT

We are indebted to Dr. Leo F. Bleyer, Pathologist to St. Joseph's Hospital for careful study of the pathological material.

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THE CLINICAL PROBLEM OF ASEPTIC MENINGITIS

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Now I would like to say a few words about *chronic aseptic meningits.* In this there are two problems, first the search for the causal organism, and second for the focus of infection. If there are no cerebral symptoms, the first thought is always of chronic osteomyelitis of a vertebra, causing a chronic epidural abscess. Vertebral pain and tenderness, and often local edema, usually provide a good clinical indication. In this category also comes the chronic adhesive arachnoiditis that occasionally follows spinal anesthetic. Brain abscess or tuberculoma usually declare themselves by cerebral symptoms, and are unlikely to remain undisclosed for long. There remains a small group of patients in whom it is often a long time before the bacteriology is established, and in this group torulosis is the commonest finding. Thus a thirty-six-year-old woman was noted to have a running ear in December, 1951, associated with severe unremitting headache that persisted a month before the patient took to bed, by now suffering from nausea as well as headache. In the following week she became very drowsy and was found to have a stiff neck. Lumbar puncture showed a pressure of 500 mm., 120 lymphocytes and 90 polymorphs. She was given aureomycin and after ten days improved, but with continued increase of cell count by lumbar puncture. She then again became drowsy and in the next two days developed confused speech and some weakness in the right limbs, and a temperature of 100°. Blurred optic discs were found and left temporal lobe abscess seemed the probable cause. The CSF pressure was 400 mm. with 80 cells (12% polymorphonuclears) and normal sugar, normal chlorides. The left temporal lobe was explored at operation but no lesion was found. A ventriculogram showed no displacement of the cerebral ventricles. She remained stuporous and on the fourteenth day the first spinal fluid which had proved sterile on ordinary media grew out cryptococcus on Sabouraud's medium. Despite many kinds of treatment in the following two and one-half years her spinal fluid still showed positive cultures of this organism, and cell counts ranging from 80 to 100 lymphocytes, sometimes a few polymorphs. Torulosis is an extraordinary infection. The most common portal of entry is a lung cavity, and there is a special liability in diabetes and with Hodgkin's disease. I know of a physician in intermittent practice when he is well enough, whose spinal fluid shows consistently approximately 45 lymphocytes and has done so for many months at a time, and whose only symptoms are recurrent headaches and dizziness, greatly improved by rest, sunshine and fresh air. It is important, of course, to exclude meningeal tuberculosis

continued on next page

in such cases, and indeed tuberculosis may develop on top of torulosis.

Occasionally a brain tumor leads to subacute or chronic aseptic meningitis. This is extremely unusual, and is most commonly a spreading sarcoma of the meninges or "meningeal sarcomatosis." Recently a patient was reported by Valaitis[10] with bronchiolar carcinoma of lung and metastases in the meninges of the posterior fossa, associated with intractable headaches, mental confusion, blindness of one eye, and variable degrees of nystagmus for three months. The initial spinal fluid showed 8 lymphocytes besides high pressure and a protein of 190 mg., but in ensuing weeks the cell count rose to 4905 "mostly lymphocytes" one week before death 3 months later. A case of our own with metastiatic melanoma of the meninges had 8 lymphocytes per cmm. for a long period.

Chronic *neurosyphilis* has not been mentioned, for this is usually fairly obvious, and a pleocytosis is unlikely without accompanying positive serology.

The remaining common cause of chronic meningeal reaction is the most important, namely *tuberculosis*. It is often the most difficult to diagnose. The difficulty arises partly because the symptoms are protean, and partly because the spinal fluid obtained by lumbar puncture often does not fairly represent the extent or intensity of the meningeal inflammation. It is the habit of meningeal tubercles to congregate most intensively at the base of the brain and there set up a thick gelatinous exudate. This exudate not only effectively blocks the circulation of spinal fluid but seals off the area of most intense inflammation. Lumbar puncture fluid may show only 30 to 100 lymphocytes per cmm. and for a long period an absence of organisms, though severe necrotizing lesions are present around the base of the brain. As in the case of cranial pyogenic disease, and in virus disease, but for a different reason, the intensity of cerebral and constitutional symptoms in relation to the mild meningeal reaction should lead to suspicion of the true state of affairs. The drop in CSF chlorides below 600 mg. is only another expression of the severity of constitutional disorder.

A more difficult type of case is where multiple chronic tuberculomas are present. For example, a colored man with a history of progressive weakness of the right arm and leg for two months, with severe headaches, had a spinal fluid pressure of 250 mm., 120 cells per cmm., of which 15 were polymorphonuclears and 105 lymphocytes. The total protein was 66 mg., sugar 51 mg., and the fluid was sterile. The cause was multiple tuberculomas of brain and cerebellum. The clinical picture resembles brain tumor, and only the meningeal reaction gives the clue to the inflammatory nature of the lesions.

Some of the problems of non-purulent meningeal reaction or "aseptic meningitis" have been reviewed. There is no easy road to their distinction from one another, no infallible test, no distinctive sign. They fall into acute and chronic types. Of the acute types one should always think first of extension of disease from the cranial sinuses, whether extradural or subdural abscess, or necrotizing encephalopathy before considering virus infection seriously. Of the chronic types, tuberculosis remains the most important to exclude, but brain abscess, chronic epidural abscess, torulosis and syphilis remain possibilities. In all these conditions it is useful to remember that a polymorphonuclear response indicates necrosis of tissue, and that the relative degrees of signs of constitutional disturbance, brain damage and of meningeal reaction will indicate the primary location of disease.

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SAVE . . . MAY 4 and 5

144th Annual Meeting of the

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AIR POLLUTION

WE RECENTLY ATTENDED a meeting of the League of Women Voters at which were present numerous men representing big civic organizations. Mr. Austin C. Daley, Air Pollution Engineer of Providence, reported to us on recent work. He has been traveling about the country interviewing officials of the Bureau of Mines and also went down into West Virginia where you may imagine that air conditions in some of the cities with big steel mills are pretty terrible. He found that industry around that way was not in full-hearted sympathy in the drive for air pollution. This, of course, is rather natural because it must entail a good deal of expense for a large manufacturing organization to take care of their smoke.

Here in Providence it is not so bad. There has been a good deal of cooperation from those who had previously polluted our air a great deal. Of course, there are some glaring examples of the opposite attitude hereabouts. One sad incidence was brought to the light of day (even though the section of the community involved had much interference with their daylight) a few months ago. One chimney had been belching smoke in the residential section for a long while and there had been many complaints made to the authorities by the dwellers therein and even by the local priest.

Now such testimony as this we would suppose might send a man to prison for homicide, but such testimony evidently is of no value before the law when a heavy cloud of smoke is the offender. It seems that the Bureau of Mines in 1868 had adopted a *smoke chart,* which in conjunction with a gadget accurately handled, might tell the exact density of smoke. This gadget had been used in the case mentioned but not at the exact number of feet suggested. Now this constituted a legal technicality and legal technicalities are much prized by law offenders, so the action brought by the pollution engineers was thrown out of court.

There is no doubt that this was a great setback to the movement for improving our atmosphere hereabouts. Let us say that it was desired to check up on the Narragansett Electric Company from which may be seen on many nights what seems like a pall of smoke. The Narragansett is surrounded by high fences. It would be very difficult to get the gadget within fifty feet of the smoke stacks, which, we believe, is the proper distance. Presumably, the *smoke chart* would be of little value in the night time. This illustrates a well-known fact that actions to improve ordinances are difficult to put into effect.

There was much cheer in some of Mr. Daley's report. He is proud of the fact that his city of

continued on next page

Providence is the only city in New England that has attempted to regulate air pollution. He also reported that down in Washington there has been an appropriation of five million dollars which Mrs. Hobby may use in investigating air pollution. He also reported that the Bureau of Mines said that he had investigated properly the smoke problem which we spoke of at the beginning of this article, and that they would attempt to develop their *smoke chart* so that it would not be so easy in the future for offenders to hide behind it. On the whole, we think we are doing pretty well hereabouts.

WE'VE DONE OUR CHILDREN WRONG

Dr. Henry E. Utter recently wrote a letter to the local paper concerning the continual despoiling of the few open places left to us in the City of Providence. Once again he referred to the seizing of the best part of Davis Park for the site of a veterans' hospital. There were many places in the state where this hospital could have been well placed; instead the people, and particularly the children of the Smith Hill district, had stolen from them what, by all rights, was necessary to them.

If ever a district needed some open space and particularly lots of playgrounds for the children, it was in the Fox Point area. There was plenty of opportunity to take a site there for a school at not a great expense; instead the children had taken from them some more playground to put up what the press refers to as "a millionaire school." Millionaires can get plenty of good education, and in past years most of them have, without such elaborate schools, but the children of Fox Point cannot well get playgrounds.

Dr. Utter points out that they are now planning to take away the small amount of park and recreation space that there is along the Seekonk River. All these things are directly contrary to what city planners insist that good cities should be. Evidently, in the opinion of our city fathers, the ideal city is what one can see from the car windows as one travels from the 42d Street Station in New York City to 125th Street.

It's high time that a little more demonstration of civic pride be shown in Providence.

REGIONAL PLANNING?

When a study commission named by the Massachusetts legislature found that the cost for a new medical-dental school in the Commonwealth presented too great a financial burden to present to the taxpayers for the return to be expected, it reported its findings accordingly.

However, on the basis of a regional compact for higher education initiated among the southern states where there was a definite need for upgrading of schools, as well as for securing professional students for rural areas, a plan for a New England higher education compact is being pushed in the northeast, with the land grant colleges, or state universities now, most vociferous in the quest for additional facilities. The need for additional professional personnel is assumed. We have yet to read a comprehensive report of what the needs are in this part of the country for doctors and dentists, how an educational compact will solve such needs if they exist, and how the program will justify the tax expense contemplated.

Perhaps the most startling evidence of the possible ramifications behind the proposal is seen in the legislation that has been placed before the Rhode Island general assembly the past two years to bind us to a regional compact. What started out, as noted above, as a solution to a way to train more physicians and dentists, is now augmented in the local legislation, which is presumably a model act for all the New England states, as follows:

> "The purpose of the New England higher education compact shall be to provide greater educational opportunities and services through the establishment and maintenance of a coordinated educational program for the persons residing in the several states of New England, parties to this compact with the aim of furthering higher education in the fields of medicine, dentistry, *veterinary medicine, public health, and in professional, technical, scientific, literary and other fields*" (italics ours).

Lest anyone be naive enough to believe that the scholarship program will be devoid of politics let him consider how Rhode Island would establish the three "resident members" who will be the state's representatives on the board of higher education for the region. One member must always be the commissioner of education who is himself a political appointee. Another is to be a citizen of the state desigated by the Governor as *his responsible representative* (italics ours).

But look how the third member is rigged as a pure political appointee! He is to be a state legislator who is a member of the Rhode Island commission on interstate cooperation. This commission has public representatives not members of the general assembly, but they are excluded; only the politically-bound members are eligible.

When a New England Workshop conference was held in Boston in 1953 to discuss this entire proposal for additional medical and dental personnel for the area the conclusion of the group pointed up the definite need for a complete study by the respective states of their individual needs. Until such a study is made in Rhode Island the general assembly should leave the regional compact proposal locked in committee files.

REPRESENTING MEDICINE

The demands upon the medical profession the past two decades for its advice and counsel has

called to the service of our communities more and more of our members who are asked to give freely of their time and talents to advance public health and welfare programs. Physicians have accepted every challenge and the unwritten history of voluntary service on local, regional and national community organizations by doctors would fill many volumes.

Rhode Island has contributed its fair share to this vital work, extending its help up to national levels on several occasions. Certainly no member has been more willing, enthusiastic and capable in carrying on multitudinous community services over and beyond the daily practice of medicine than our Doctor Charlie Farrell of Pawtucket. It is little wonder, then, that when the need arose recently for a Medical Advisory Committee to the U. S. Department of Health, Education and Welfare he was a logical choice to be numbered among the appointees.

The new fourteen-member national advisory committee to the Social Security Administration meets monthly in Washington to consider medical aspects of administering the new "disability freeze" provision in the social security law. This provision is similar to the waiver of premium in commercial life insurance, and it permits a worker to keep his old age and survivor's rights intact when he is totally disabled for work for an extended period. The committee will set up guides and procedures for obtaining and interpreting medical evidence as to existence and extent of disability.

To our Charlie Farrell, and others like him who serve as the "representatives of medicine" with their only reward that of the satisfaction of serving the public and the profession for the good of both, our sincere appreciation and thanks. Their service is "beyond the call of duty," and it therefore merits the commendation of every physician.

HARD TO BEAT

Each year the committee on arrangements for the annual meeting spends considerable time and effort in planning a diversified and interesting program for the entire membership at the annual session of our organization. This task has been going on now for one hundred forty-three years. Undoubtedly each arrangements group, and justifiably so, considers that its efforts have produced one of the outstanding sessions in the long history of this medical society.

Certainly the scientific programs through the years have brought renown to our organization, and few larger medical groups have been able to present more able and notable speakers to their physicians at annual conferences. It is difficult to better a previous program these days, but we are inclined to express an advance opinion that this year's session really stands out.

To top a galaxy of brilliant medical lecturers on a wide range of medical and surgical subjects with a Chapin orator who has within the past six months been awarded the world-renowned Nobel prize for medical scientific research, and a dinner speaker whose career in the United States Navy has made him a hero warranting a biographical motion picture recording, is hard to beat.

Certainly every member of the society should check the May 4 and 5 dates for attendance at the fine lectures at his own Medical Library, which incidently has recently undergone renovation adding further luster to the setting for the 144th Annual Meeting.

PHYSICIANS AND THE CHAMBER OF COMMERCE

The Greater Providence Chamber of Commerce is currently engaged in a program for increased prosperity for the metropolitan Providence area. At the March meeting of the district medical association the views and plans of the Chamber of Commerce were excellently set forth by Mr. Thomas F. Gilbane, its president.

Physicians are asked to support many community programs and agencies. We feel certain that a complete check of all the various community interests would find medical representation involved in each one. The Chamber of Commerce has stated that it seeks the counsel of physicians for its standing committees because of their unusual knowledge of community problems over and above health. For example: physicians are probably more aware of traffic conditions than any other group, for every doctor is faced with all the problems of motoring in the discharge of his daily visits to the four corners of our large metropolitan area.

The principles of medical ethics of the American Medical Association, to which we all subscribe, includes the provision that "'Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interest of humanity. . . ."

The health of a community is tied up in no small measure with its economic security which involves many factors in a large metropolitan area. Providence has a problem to improve its economic health. The Chamber of Commerce has launched a well-conceived program for a solution of the problem. The need for physician-members of the Chamber has been expressed. Every physician in the metropolitan district will be solicited by mail to join in the achievement of a finer and more prosperous Greater Providence. Give heed to the call to this fine community service!

15th ANNUAL CONGRESS ON INDUSTRIAL HEALTH

WASHINGTON, D. C., JANUARY 25-26, 1955

REPORT OF STANLEY SPRAGUE, M.D., *Representative of the Rhode Island Medical Society*

THE MAIN SESSIONS of the Congress on Industrial Health were preceded by general meetings of members of the AMA Council on Industrial Health, state medical society representatives, and the district councilors of the Industrial Medical Association.

Doctor Hirsch, recently assigned to the consideration of legal problems of the activities of the council on industrial health, spoke at length at the first general meeting on corporation and medical practice, pointing out many lines of conflict in which corporation medicine was not only unethical, but also illegal. He left the impression with your representative that in compensation cases there is very little to be withheld from the court in what is commonly known as "privileged communications."

The congressional legislative picture was presented by Doctor Frank Wilson, head of the AMA Washington office. He stated that there were already an estimated one hundred and twenty medical bills to be presented to the present session of congress. Highlights of his comments were: 1) the trend by labor for demanding bigger fringe benefits, 2) the impetus for a federal subsidy to the states to establish a formula for insurance costs in every industrial compensation case, 3) interest in air and water pollution studies with the responsibility for financing such programs divided between the individual states and the federal government, 4) rehabilitation programs covering the aged, sick and the infirm, 5) proposals for employee health coverage, the care of relatives of soldiers for overseas federal employees and domestic civil employees.

A report from Doctor McLanahan, chairman of the committee for the revision of Standing Orders for Nurses in Industry, offered a clear-cut picture of present problems and showed that his committee has formulated a rather different concept than held formerly by many in the industrial health field. When revised completely and approved, the new manual will be published as guiding principles for nurses in occupational medicine.

It was reported that eight state medical societies including Rhode Island, have so far given their approval to the publication of Guiding Principles for Occupational Medicine.

At the second general meeting a report from the office of vocational rehabilitation indicated that more than 250,000 persons need rehabilitation services every year, and the office listed a backlog of an estimated two to six million persons seeking assistance. The finding, treatment and training of the disabled naturally requires multiple activity which may be realized to some extent through provisions in the revised Hill-Burton bill through which schools may train more trained personnel to carry on this essential work of rehabilitation services.

The Public Health Service reported a small budget has hampered its growth. It is willing to offer consultant service to the states in public health matters to the best of its ability.

Few states had anything new to report. In the larger industrial centers some states reported seminars on industrial health have been held with varying success as regards attendance by physicians in general practice. The armed services are reported to be endeavoring to employ civilian physicians in naval units along the entire Atlantic coast, but such physicians must accept a civil service status. The low rate of compensation was seen as a factor in the failure to attract many physicians to this work.

The day prior to the opening of the conference the state delegates attended a scientific session at the National Instrutes of Health at Bethesda, Maryland. All the delegates, I am sure, were impressed by the tremendous size of the institute centers with their complete laboratory equipment in every division. Our attention was called to the fact that any individual physician in the country having a baffling case on which a tentative diagnosis has been made may on application have his patient admitted to the National Institute, provided that the institute has at that time a similar type of condition under investigation. Also, any physician may request that his name be placed on the mailing list and thereby receive a monthly brochure of the activities in progress.

Doctor Melvin N. Newquist, medical director of the Texaco Company, presided at the opening general session of the congress at which the status of the health of the working population was reviewed by Dr. A. G. Kammer of the University of Pitts-

concluded on page 22

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Cross section of active duodenal ulcer.

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INDUSTRIAL HEALTH CONGRESS

concluded from page 218

burgh School of Public Health, and a four-member panel discussed what is needed to do a better job in industrial health from the viewpoint of industrial hygiene, industrial nursing, industrial medicine, and official health agencies.

At the second session of the congress, Mr. Charles E. Tosch of New York gave an interesting review of recent trends in providing major medical expense insurance, stating that several insurance companies are proceeding with a policy to cover such disabilities as heart disease, tuberculosis, mental illness, etc., up to a stated maximum after a deductible payment of $100 or more to be paid by the insured. This proposal is also on the lines presented by our Dr. Joseph C. O'Connell, in his address to the corporation of Physicians Service at its annual meeting in Providence in January.

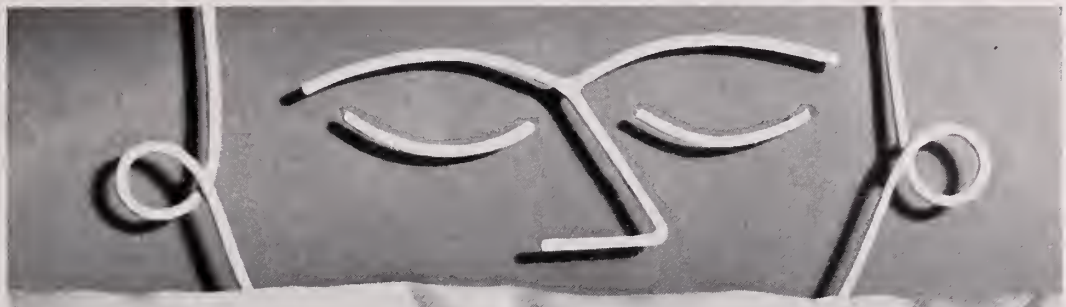
Continuing the talks on industrial medicine and the economics of medical care, Doctor F. Benedict Lanahan, medical director of the Electric Storage Battery Company of Philadelphia, said the present condition of state cash sickness compensation programs was a challenge to the medical profession to organize more fully against socialized medicine. Doctor James R. McVay, member of the board of trustees of the AMA, warned against unnecessary hospitalization given with the hope that the insurance coverage would stand for the cost.

On the subject of workmen's compensation, Mrs. Anne Ramsay Somers of the workmen's compensation division in Washington, stated that the medical profession will more and more be responsible for the successful operation of state workmen's compensation programs. Doctor Robert O'Connor of the Liberty Mutual Insurance Company, spoke of the high cost of group plans generally, stating that some cost from three to ten times workmen's compensation program costs, and he expressed the opinion that group costs for employee illnesses not related to compensation cases could be greatly reduced by intelligent control of cases.

Conclusions your delegate drew from the conference included those that the general practitioner is the key man to reach for greater progress in industrial medicine, that more attention must be paid by every physician to rehabilitation of the injured or ill workman, that there should be detailed studies undertaken by those industrial firms that constantly employ physicians, or have regular consulting physicians on their staff.

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C I B A Summit, N. J.

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PROGRAM . . . 144th ANNUAL MEETING

RHODE ISLAND MEDICAL SOCIETY

May 4-5, 1955 *At the Rhode Island Medical Society Library, Providence*

WEDNESDAY, MAY 4

1:00-1:45 P.M. REGISTRATION AND TOUR OF TECHNICAL EXHIBITS

1:45 P.M. CALL TO ORDER

GREETINGS FROM THE PRESIDENT, HENRI E. GAUTHIER, M.D.

2:00 P.M. "THE IMPORTANCE OF PLASMA PROTEIN ABNORMALITIES IN MYELOMATOSIS"

HERMAN A. LAWSON, M.D., of Providence, Rhode Island

(Chief of Medical Service, Veterans Administration Hospital, Providence)

2:30 P.M. "DIAGNOSTIC SIGNIFICANCE OF A LUMP IN THE NECK"

HAYES MARTIN, M.D., of New York City

(Attending Surgeon, Memorial Hospital; Associate Professor of Clinical Surgery, Cornell Medical College, New York)

3:00 P.M. "CRITIQUE OF NEW DRUGS"

DALE G. FRIEND, M.D., of Boston, Massachusetts

(Associate Professor of Medicine, Harvard Medical School)

3:30-4:00 P.M. INTERMISSION TO VISIT TECHNICAL EXHIBITS

4:00 P.M. "THE USE AND ABUSE OF HORMONE THERAPY"

SOMERS H. STURGIS, M.D., of Boston, Massachusetts

(Surgeon [Gynecology], Peter Bent Brigham Hospital; Associate Clinical Professor of Gynecology, Harvard Medical School)

4:30 P.M. PRESIDENTIAL ADDRESS

HENRI E. GAUTHIER, M.D., of Woonsocket, Rhode Island

(President, Rhode Island Medical Society)

5:00 P.M. GENERAL SESSION OF THE SOCIETY

INSTALLATION OF OFFICERS FOR 1955-56

5:30-6:30 P.M. TOUR OF TECHNICAL EXHIBITS

continued on page 224

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Reference to RHINALGAN:

1. Von Alyeo, O. E., ond Donnelly, W. A.: E.E.N.&T. Monthly, 31, Nov. 1952.
2. Fox, S. L.: AMA Arch. Otoloryn., 53, 607-609, 1951.
3. Molomut, N., ond Horber, A.: N.Y. Phys., 34, 14-18, 1950.
4. Lett, J. E., (Lt. Col. MC-USAF) Research Report, Dept. Otoloryn., USAF School Aviot. Med., 1952.
5. Homilton, W. F., ond Turnbull, F. M.: J. Amer. Pharm. Ass'n., 7, 378-382, 1950.
6. Browd, Victor L.: Rehobilitotion of Heoring, 1950.
7. Kugelmoss, I. Newton: Hondbook of the Common Acute Infectious Diseoses, 1949.

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EVENING SESSION

7:30-8:30 P.M. REGISTRATION AND TOUR OF TECHNICAL EXHIBITS

8:30 P.M. "CRYPTORCHIDISM"

CHARLES HIGGINS, M.D., of Cleveland, Ohio

(Head of Department of Urology, Cleveland Clinic; Past President of American Urological Association)

9:00 P.M. CHARLES V. CHAPIN ORATION—"THE GROWTH OF POLIOMYELITIS VIRUS IN TISSUE CULTURE: APPLICATIONS TO DIAGNOSIS AND PREVENTION OF POLIOMYELITIS"

JOHN F. ENDERS, Ph.D., of Boston, Massachusetts

(Chief, Research Division of Infectious Diseases, Children's Medical Center, Boston; Associate Professor of Bacteriology and Immunology, Harvard Medical School; Recipient of Passano Award 1953, Lasker Award 1954, Kimble Methodology Research Award 1954, Nobel Prize in Physiology and Medicine 1954)

10:00 P.M. RECESS AND TOUR OF EXHIBITS

THURSDAY, MAY 5

2:00 P.M. CALL TO ORDER. *President,* HENRI E. GAUTHIER, M.D.

RECOGNITION OF DELEGATES FROM OTHER SOCIETIES

2:15 P.M. "THE MANAGEMENT OF CHILDREN WITH ABDOMINAL PAIN"

JAMES MARVIN BATY, M.D., of Boston, Massachusetts

(Professor of Pediatrics, Tufts College Medical School; Physician-in-Chief, The Boston Floating Hospital)

ORVAR SWENSON, M.D., of Boston, Massachusetts

(Clinical Professor of Pediatric Surgery, Tufts College Medical School; Surgeon-in-Chief, The Boston Floating Hospital for Infants and Children)

CARROLL A. BERMAN, M.D., of Boston, Massachusetts

(Clinical Instructor in Radiology, Tufts College Medical School; Roentgenologist, The Boston Floating Hospital)

3:15-3:45 P.M. INTERMISSION TO VISIT TECHNICAL EXHIBITS

3:45 P.M. "PROGRESS NOTES ON THE SURGERY OF ACQUIRED HEART DISEASE"

DWIGHT E. HARKEN, M.D., of Boston, Massachusetts

(Associate Clinical Professor of Surgery, Harvard Medical School; Surgeon, Peter Bent Brigham Hospital; Chief of Thoracic Surgery, Mt. Auburn Hospital, Boston)

concluded on page 226

from an editorial in the J.A.M.A.
(156:991, Nov. 6, 1954):

Oral broad spectrum antibiotic therapy
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4:15 P.M. "NEGLECTED ASPECTS OF THE TONGUE IN MEDICAL PRACTICE"

WILLIAM B. BEAN, M.D., of Iowa City, Iowa

(Professor of Medicine, Head of Department of Internal Medicine, State University of Iowa College of Medicine; Senior Medical Consultant of the Veterans Administration, Iowa City)

6:00-7:00 P.M. RECEPTION . . . At the Narragansett Hotel

(For members of the Society and their guests)

7:00 P.M. DINNER . . . At the Narragansett Hotel

(For members of the Society and their guests)

9:00 P.M. Anniversary Chairman: ORLAND F. SMITH, M.D.

(Treasurer, Rhode Island Medical Society Physicians Service; Chief of Surgical Service, Pawtucket Memorial Hospital)

Greetings

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HEALTH EDUCATION BROADCASTS

Radio station WPRO initiated on March 19, the series of health education broadcasts prepared by the American Medical Association on problems of adolescence. The programs are broadcast on Saturdays at 3:45 P.M. Programs on "Health in the Summer" will be broadcast during June, July and August, and a new series on school health will be presented in the fall months. These series of health education programs are being presented by WPRO in cooperation with the Providence Medical Association through its committee on public relations.

IF YOU DRIVE TO ATLANTIC CITY

With the annual sessions of the American Medical Association scheduled for Atlantic City this June 5-10, many physicians from Rhode Island will undoubtedly plan to motor to the famous New Jersey shore resort. We are advised that the best route is to cross the George Washington bridge at New York and take the New Jersey turnpike.

At Interchange No. 11 on the Jersey turnpike enter the Garden State Parkway which is the new scenic highway along the coastal plain. Driving time from New York is reported to be a little over two hours.

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---

1. Taggart, H. A.: Protein Metabolism in Relation to Nutritional Aspects of Medical Diseases, Pennsylvania M.J. *54*:339 (1951).
2. Marquardt, G. H.; Cummins, G. M., and Fisher, C. I.: Blood Protein Replenishment in Treatment of Nephritic Edema, Quart. Bull. Northwestern Univ. M. School *26*:140 (1952).
3. Kark, R. M.: Low Sodium and High Protein Diets in Laennec's Cirrhosis, M. Clin. North America *35*:73 (1951).
4. Kekwick, A.: Protein Deficiency in Surgical Patients, Ann. Roy. Coll. Surgeons England 7:390 (1950).
5. Stieglitz, E. J.: Nutrition Problems of Geriatric Medicine, Report of Council on Foods and Nutrition, J.A.M.A. *142*:1070 (Apr. 8) 1950.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, February 7, 1955. In the absence of the president, the meeting was called to order by Doctor Robert R. Baldridge, Vice President, at 8:30 P.M.

Minutes of Previous Meeting

The minutes of the previous meeting were omitted as they were published in the RHODE ISLAND MEDICAL JOURNAL.

Announcements by Vice President

Doctor Baldridge called to the attention of the members the Eastern Regional Meeting of the American College of Surgeons to be held in Providence on March 3, 4 and 5, and the meeting scheduled on Monday, March 7, of the Providence Medical Association at which Doctor Frank Dickinson, Director of the Bureau of Economic Research of the American Medical Association, would speak.

Death of Doctor J. Joseph Hoey

Doctor Baldridge noted with regret the death of Doctor J. Joseph Hoey, a practicing physician in Providence for forty-four years, and he noted that a committee to prepare the Association's tribute to Doctor Hoey would be named by Doctor Chafee.

Scientific Program

Doctor Baldridge introduced Doctor John M. Loré, Jr., of New York City, Surgical Staff, Department of Surgery, and Surgical Research Laboratories at St. Clare's Hospital in New York City, who spoke on "The Pathogenesis of Ascites and a Consideration of Natural Occurring Porto-Caval Shunts."

Doctor Loré gave a very illuminating and provocative talk on this most interesting subject. His talk was supplemented by the use of excellent kodachrome slides. He injected colored liquid latex into his pathological specimens which were later photographed to illustrate the greater part of his talk. He stated that ascites was due to an intrahepatic portal block. In other words, it is due to a primary diffuse blockage of the outflow tract of the liver, namely the hepatic veins.

Doctor Loré's investigations have convinced him that portal blockage is merely secondary in the presence of ascites. There was a big question in the speaker's mind after all of his investigations, whether or not spleno-renal and porto-caval shunts are of much value.

A very interesting discussion followed Doctor Loré's talk.

The meeting adjourned at 10:00 P.M.

Collation was served.

Attendance was 87.

Respectfully submitted,

MICHAEL DIMAIO, M.D., *Secretary*





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C I B A *Summit, N. J.*

ON THE MEDICAL LIBRARY BOOKSHELVES

Fellows of the Rhode Island Medical Society are reminded that they now have the privilege of borrowing books from the Davenport Collection, our interesting collection of volumes by and about physicians. These include fiction, biographies, travel, poetry and history. There have been several recent "best sellers" added and some of the new titles are listed below:

Otho T. Beall, Jr. and Richard H. Shryock—Cotton Mather: First Significant Figure in American Medicine. Publications of the Institute of the History of Medicine, First Series: Monographs, Volume V. Johns Hopkins Press, Balt., 1954. The authors of this new biography feel that too much emphasis has been placed on Cotton Mather, theologian, and too little on Cotton Mather, physician. They discuss his contributions to medicine and have included selected sections from The Angel of Bethesda, Mather's unpublished textbook of medicine. The Library has two Mather titles in its rare book collection.

Estelle Brodman—The Development of Medical Bibliography. Medical Library Association, Publication No. 1. Balt., 1954. This is particularly a librarian's book but should interest any physician who likes to look up his own references. The most important works in the history of medical bibliography are discussed thoroughly; lesser works are listed in the appendix.

Jeremiah S. Finch—Sir Thomas Browne. A Doctor's Life of Science & Faith. Henry Schuman, N. Y., 1950. In 1642, a general practitioner in Norwich England, wrote a "best seller" — Religio Medici. This small book is still popular and its author still a favorite subject for biographers. Dr. Finch is an authority on Sir Thomas Browne.

Benjamin Franklin—Some Account of the Pennsylvania Hospital. Originally published by B. Franklin & D. Hall, Philadelphia, 1754. Printed in facsimile, with introduction by I. Bernard Cohen. Publications of Institute of History of Medicine, fourth series, Bibliotheca medica americana, volume VI. Johns Hopkins Press, Balt., 1954.

Joseph Garland, M.D.—All Creatures Here Below. Houghton Mifflin Co., Bost., 1954. The jacket says "Ages 9-12" but this delightful little book has appeal for an older audience as well. Rene Martin's illustrations are fine.

John Jennings—Banners Against the Wind. Little, Brown & Co., Bost., $3.75. This is a biographical novel about Samuel Gridley Howe, M.D. covering the first years of his medical career, when he served as a doctor in the Greek war for independence against the Turks, up to the time of his marriage to Julia Ward.

Robert B. Robertson, M.D.—Of Whales and Men. Alfred A. Knopf, N. Y., 1954. This is a fascinating account of a modern whaling expedition. Dr. Robertson served as senior medical officer to the expedition and the tale of his experiences makes exciting reading. Today's whaling ship is a factory, but the whaling men seem not to have changed a great deal since the days of Herman Melville.

Henry E. Sigerist, M.D.—Man and Medicine. An Introduction to Medical Knowledge. Introduction by Dr. William H. Welch. Translated by Margaret Galt Boise. W. W. Norton & Co., Inc., N. Y., 1932. This was written for laymen, especially for the young person contemplating the study of medicine.

Morton Thompson—Not as a Stranger. Charles Scribner's Sons, N. Y., 1954. This story of the making of a doctor has headed reading lists for many months.

William Carlos Williams, M.D.—The Desert Music. Random House, N. Y., 1954. Dr. Williams, in spite of a busy life as a practicing physician, has found time to win many of the major prizes for poetry and to become one of our most important literary figures.

Recent Day Fund purchases are:

Maude E. Abbott—Atlas of Congenital Cardiac Disease. Originally published by the American Heart Association, N. Y., 1936. Facsimile of the original edition, printed 1954.

Jesse E. Edwards et al—An Atlas of Congenital Anomalies of the Heart and Great Vessels. Charles C. Thomas, Springfield, Ill., 1954.

Joseph Fletcher—Morals and Medicine. The Moral Problems of: The Patient's Right to Know the Truth, Contraception, Artificial Insemination, Sterilization, Euthanasia. Princeton University Press, Princeton, 1954.

Joseph Garland, editor—The Physician and His Practice. Little, Brown and Co., Bost., 1954.

Henry Gray—Anatomy of the Human Body. Ed-

continued on page 232


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continued from page 230

ited by Charles Mayo Goss. 26th ed. Lea & Febiger, Phil., 1954.

J. P. Greenhill—Office Gynecology. 6th ed. Year Book Publishers, Inc., Chic., 1954.

Handbooks of operative surgery:

R. H. Flocks and David Culp—Surgical Urology. Year Book Publishers, Inc., Chic., 1954.

J. P. Greenhill—Surgical Gynecology Including Important Obstetric Operations. Year Book Publishers, Inc., Chic., 1952.

Julian Johnson and Charles K. Kirby—Surgery of the Chest. Year Book Publishers, Inc., Chic., 1952.

Charles B. Puestow—Surgery of the Biliary Tract. Pancreas & Spleen. Year Book Publishers, Inc., Chic., 1953.

Claude E. Welch—Surgery of the Stomach & Duodenum. Year Book Publishers, Inc., Chic., 1952.

Eddy D. Palmer—The Esophagus and Its Diseases. Paul B. Hoeber, Inc., N. Y., 1952.

E. A. Spiegel, editor—Progress in Neurology and Psychiatry. An Annual Review. Volume IX. Grune & Stratton, N. Y., 1954.

Year Book of General Surgery (1954-1955 Year Book Series). Edited by Evarts A. Graham. With a Section on Anesthesia Edited by Stuart C. Cullen. The Year Book Publishers, Chic., 1954.

Year Book of Radiology (1954-1955 Year Book Series). Radiologic Diagnosis Edited by John Floyd Holt and Fred Jenner Hodges. Radiation Therapy Edited by Harold W. Jacox and Morton M. Kligerman. The Year Book Publishers, Inc., Chic., 1954.

Review volumes received from the Rhode Island Medical Journal were:

George Clinton Andrews—Diseases of the Skin for Practitioners and Students. 4th ed. W. B. Saunders Company, Phil., 1954.

J. Englebert Dunphy and Thomas W. Botsford—Physical Examination of the Surgical Patient. W. B. Saunders Company, Phil., 1953.

Ed Kilman and Theon Wright—Hugh Roy Cullen. A Story of American Opportunity. Prentice-Hall, Inc., N. Y., 1954.

Surgical Forum. Proceedings of the Forum Sessions, Thirty-ninth Clinical Congress of the American College of Surgeons, Chicago, Illinois, October, 1953. W. B. Saunders Company, Phil., 1954.

Gifts—we have received the following items from the Fellows of the Society:

Dr. Howard E. Blanchard: forty-seven textbooks.

Dr. Peter Pineo Chase: eighteen textbooks and three paintings illustrating "Pain."

Dr. Frank W. Dimmitt: Transactions of the American Academy of Ophthalmology and Otolaryngology, 39th—44th, 1934-39.

Dr. Roland Hammond: medical journals and Samuel Raynor Meaker—A Doctor Talks to Women. Simon and Schuster, N. Y., 1954.

Dr. A. Lloyd Lagerquist: medical journals.

Dr. Ira H. Noyes: An Abridgement of the Practice of Midwifery: and a Set of Anatomical Tables With Explanations. Collected from the Works of the Celebrated William Smellie. Bost., 1786. This book was given to Doctor Noyes by Dr. James H. Davenport. We are pleased that Doctor Noyes saw fit to give it to the Library.

Dr. H. G. Partridge: a framed letter from Lawson Tait, M.D. to H. R. Brown, M.D. and

Felix Flügel—A Dictionary of the English and German Languages for Home and School. Edited by Prof. Im. Schmidt and G. Tanger. Brunswick. 1901.

Dr. F. Ronchese: medical journals and pamphlets and

The School of Salernum. Regimen Sanitatis Salerni. The English Version by Sir John Harington. Ente Provinciale per il Turismo, Salerno.

Atti XI Congresso Internazionale di Medicina del Lavoro, Napoli 13-19 Settembre 1954. Volume Primo. Napoli, 1954.

Dr. Florence M. Ross: medical journals.

Gifts from non-members include:

American Cancer Society, Inc.: Committee on Growth of the National Academy of Sciences—National Research Council. Eighth Annual Report to the American Cancer Society, Inc. July 1952-June 1953. Wash., (1954).

Fourth Report on Institutional Research Grants of the American Cancer Society. September, 1952-August, 1953. N. Y., 1954.

American Medical Association: County Medical Public Relations Manual. Chic.

Association of American Physicians: Transactions of the Association of American Physicians, vol. 67, 1954.

Professor Robert T. Beyer: copies of Acta Oto-Laryngologica, Excerpta Medica Section XI, and Journal of Speech and Hearing Disorders.

Rabbi William G. Braude: six textbooks.

Fremont Research Foundation, Inc.: John E. Gregory—Pathogenesis of Cancer. 2nd ed. Pasadena. 1952.

Markle Foundation: 1953-54 Annual Report of the John and Mary R. Markle Foundation. N. Y., 1954.

Miriam Hospital: six volumes of Science.

Nutrition Foundation: Report of the Scientific Director of The Nutrition Foundation, Inc. N. Y., 1954.

Mrs. E. H. Paine: three textbooks and ten diplomas from the estate of John Combe Pegram, Jr.

St. Joseph's Hospital: H. Morriston Davies—Surgery of the Lung and Pleura. Lond., 1930.

concluded on page 235

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concluded from page 232

Mr. Morton Saunders, Ciba Pharaceutical Products, Inc.: The Rauwolfia Story. From Primitive Medicine to Alkaloidal Therapy. Summit, N. J., 1954. 2 copies.

Miss M. A. Terpany: twenty-one textbooks and pamphlets.

Veterans Administration Hospital: several volumes of medical journals and a copy of Books in Print 1953.

Books received through exchange

We have an agreement with the University Library, Lund, Sweden to receive copies of their medical theses in exchange for our Rhode Island Medical Journal. The following titles have been sent to us:

Erik Akerlund—A Study in Acute Head Injuries Examined with Flicker Fusion Determined under the Influence of Evipan. Stockholm, 1953.

David Berezin—Pelvic Insufficiency During Pregnancy and After Parturition. Lund, 1954.

Nils Bergh—Clinical and Experimental Studies in Myasthenia Gravis. Lund, 1953.

Karl Gustav Dahlgren—On Suicide and Attempted Suicide. A Psychiatrical and Statistical Investigation. Lund, 1945.

Gunnar Engleson—Studies in Diabetes Mellitus. Lund, 1954.

Rune Grubb—Some Aspects of the Complexity of the Human ABO Blood Groups. Copenhagen, 1949.

Henry Jedberg—A Study on Genital Tuberculosis in Women. Lund, 1950.

Ivar Nilsby — Non-bacterial Meningo-encephalitides in Children with Special Reference to Spontaneous Post-catarrhal and Varicella Meningoencephalitis. Lund, 1953.

Stig Radner—Vertebral Angiography by Catheterization. A New Method Employed in 221 Cases. Lund, 1951.

Gerdt Wretmark—The Peptic Ulcer Individual. A Study in Heredity, Physique, and Personality. Copenhagen, 1953.

NOTICE

Fellows may obtain single copies or full sets of the duplicate transactions of the Rhode Island Medical Society, 1859-1912, (unbound) at the Library.

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200 paid 6% or higher
233 paid 5% to 6%
237 paid 4% to 5%
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BOOK REVIEWS

FUNDAMENTALS OF ANESTHESIA. Prepared under the Editorial Direction of the Consultant Committee for Revision of Fundamentals of Anesthesia, a publication of the Council on Pharmacy and Chemistry of the American Medical Association. Third edition. W. B. Saunders Company, Phil., 1954. $6.00

This is the third, and by far the best of the deservedly popular AMA publications titled FUNDAMENTALS OF ANESTHESIA. In its original edition, this monograph was intended chiefly for the use of medical officers of the Armed Forces; for their basic instruction in anesthetic techniques and for proper handling of depressed states of the circulation and respiration.

So admirably did the initial volume fill these requirements that it became very popular as a teaching text and reference manual for internes and residents.

In this third edition, the book has been greatly enlarged. Its format has been changed, the material expanded and rearranged, and the various subject headings so exhaustively treated that it has now become a very valuable general reference work for those interested in almost any phase of anesthesiology.

The Committee, composed of outstanding authorities in their respective fields, has done a splendid job in condensing an enormous volume of information into 279 pages. Printing and illustrations are excellent and the book is well indexed.

FUNDAMENTALS OF ANESTHESIA is highly recommended to medical students, residents in anesthesia, part-time or full-time anesthesiologists and all other medical practitioners who might occasionally require a condensed, highly accurate and very authoritative reference work on that most fascinating of specialties, anesthesia.

HARRY E. DARRAH, M.D.

PRACTICE OF ALLERGY, by Warren T. Vaughan, M.D. Revised by J. Harvey Black, M.D. The C. V. Mosby Co., St. Louis, 1954. $21

PRACTICE OF ALLERGY was first written by Dr. Vaughan about fifteen years ago. A second edition followed five years later and the present volume is the third edition. This volume was extensively revised by J. Harvey Black who brought it up to date. This book was hailed widely from the very beginning, and its popularity continues to increase with the passage of time.

Specialists, practitioners and students will find this book complete in every respect. It will serve as as excellent reference book as well as to give complete information on a vast number of allergic subjects. The book is well organized, and is divided into sixteen parts. In Part 1 the authors present numerous historical references leading to our present understanding of clinical allergy. Then come six chapters on the characteristics of clinical allergy, and two chapters on the physiology of allergy. The diagnosis of specific sensitivities is thoroughly discussed in twelve separate chapters. The entire list of subjects is too long to enumerate in detail.

The latest information on pollen surveys and pollen counting is presented by Oren C. Durham. Mold allergy is brought up to date by Dr. James B. Howell. A very important new chapter on pulmonary function is added for the first time to the third edition.

Food allergy is treated most admirably. In addition to the presentation of available knowledge on this subject, there are excellent practical chapters on trial diets, with extensive lists of menus and recipes. For those patients who are obliged to avoid certain allergenic foods, abundant lists of substitute foods are provided, so that they may be assured of an adequate dietary program. Other worthwhile features in this book are too numerous to describe in this review. For those who have an interest in the field of allergy this book is heartily recommended.

STANLEY S. FREEDMAN, M.D.

UROLOGY. Edited by Meredith Campbell, M.D. Vols. I, II and III. W. B. Saunders Company, Phil., 1954. $60.00

Dr. Campbell, with the collaboration of fifty-one other authorities in urology, has edited a three-volume classic on modern urology.

The subject matter is comprehensively brought up to present day concepts.

The contents are well organized, with the first volume introducing a detailed account of the anatomy and physiology of the G.U. system. The prin-

ciples of diagnosis are then discussed and correlated with the anatomy and physiology. The remainder of the first volume covers pathology of urinary tract obstruction, anomalies of the urogenital tract, infections of the urogenital tract, infertility in the male, and urinary lithiasis. The section on the anomalies of the urogenital tract gives a clear and concise correlation between the embryology and the anomalies that are encountered in the child and adult.

The second volume covers injuries, tumors, neuromuscular diseases of the urinary tract, urology in the female, and urology in infancy and childhood. The section on tumors of the urogenital tract gives the most complete and detailed descriptions of these entities that can be found in any urology text. The chapters on traumatic injuries of the urogenital tract is noteworthy for it gives an excellent discussion of the diagnosis and treatment of these problems when they are encountered. The portion that is devoted to ruptured bladders and urethras gives an excellent description, supplemented with diagrams, of the various sites where injury may occur in the lower portion of the G.U. tract.

Volume three is devoted almost entirely to methods and procedures of urologic surgery. The final section of the volume is devoted to the diagnosis and treatment of medical diseases of the kidney, and the physiology and treatment of disturbances of the adrenal gland.

These up-to-date and complete volumes on urology would be of advantage to any physician as a reference even though he is not practicing urology. It is highly recommended to the urologist as an up-to-date text.

VINCENT I. MACANDREW, M.D.

DISEASES OF THE SKIN: FOR PRACTITIONERS AND STUDENTS by George Clinton Andrews, M.D. W. B. Saunders Company, Philadelphia, 1954. 4th ed. $13.00

This latest edition of Andrews' text on diseases of the skin has certain qualities which will appeal to many readers, but has others which the reviewer found leave it open to criticism.

The book commences with a brief consideration of the anatomy and pathology of the skin. The remaining pages are devoted to a chapter on symptomatology and general diagnosis, three chapters on radiation physics and therapy, one on surgical diathermy and thirty-two chapters on the diagnosis and treatment of diseases of the skin. The material is presented clearly and in interesting fashion and brings the older edition up to date in regard to such things as the cyclic nature of hair growth, the biochemistry of melanin formation, new stains, porphyria, industrial dermatoses, and advances in therapy. The print is clear, the paper excellent and the photographs, in general, are very good.

concluded on page 240

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BOOK REVIEWS

concluded from page 237

Criticism might be made of the occasional recommendation of a form of therapy only recently introduced and not as yet generally accepted. As an example might be cited the author's recommendation of vitamin B_{12} in the treatment of psoriasis, a form of therapy which in the reviewer's small series of cases has proven to be of little value. In regard to the management of hemangiomas, Andrews states that spontaneous involution is usually incomplete and accompanied by more scar formation than would result from proper therapy. Such a statement would be strongly contested by many well-trained and experienced dermatologists who believe that spontaneous involution frequently occurs and with excellent cosmetic results, and that observation alone is indicated in many cases. One might also question the statement that post mortem examination of patients with Kaposi's sarcoma usually reveals visceral involvement.

Perhaps the greatest objection to this textbook, in the opinion of the reviewer, is that it is neither a short, concise work which would be of value to the non-dermatologist and student, nor a lengthy and complete text which would be of value primarily to the dermatologist. It represents what perhaps might be considered a compromise. For those who prefer neither the short nor the long this text of Andrews can be recommended.

ARTHUR B. KERN, M.D.

REVIEW OF MEDICAL MICROBIOLOGY by Ernest Jawetz, M.D., Joseph L. Melnick, Ph.D., and Edward A. Adelberg, Ph.D., Lange Medical Publications, Los Altos, California, 1954. $4.50

There has been a definite need for a brief, accurate and current review of the various phases of medical microbiology, particularly those concerned with clinical infections and chemotherapy. The book fulfills the need well. The subject matter covers medical bacteriology, medical mycology, serologic procedures, and there is an adequate and up-to-date coverage of the virus and rickettsial agents of disease, a field that is continually changing in concept and technique. A considerable portion of this review is devoted to a discussion of basic science, and this is a definite advantage to students in microbiology courses, student technologists, and the medical student who is preparing for board examinations. However, the review is directed primarily at the physician by stressing the clinical and chemotherapeutic aspects of medical microbiology.

A shortcoming that soon becomes apparent on reading this review is the failure to include references to the original literature and especially current sources of information at the end of each chapter so that the student, and especially the professional microbiologists might readily find a more detailed discussion of a given subject. The publishers have indicated that a new edition will be published every two years. This will be welcome to a field that is continually changing, and especially welcome would be references to the interim literature.

RAYMOND M. YOUNG, Ph.D.

SURGERY OF THE PANCREAS by Richard B. Cattell, M.D., and Kenneth W. Warren, M.D. W. B. Saunders Company, Phil., 1953. $10.00

A book of 374 pages which was released several months ago. It is a most comprehensive volume, covering the anatomy and physiology in minute detail. Congenital malformation and infection, both acute and chronic, are dealt with in a liberal manner. The surgical diseases include cysts and their classification, pancreatic injuries, islet cell adenomas and hyperinsulinism, and are discussed in detail. Malignancy is treated by itself with an interesting chapter on all of the details, including technique of the various operations. The book is based on experiences with over 1,000 patients with surgical disease of the pancreas treated at the Lahey Clinic. It contains 100 illustrated figures of X ray, surgical specimens, anatomical drawings and photographs.

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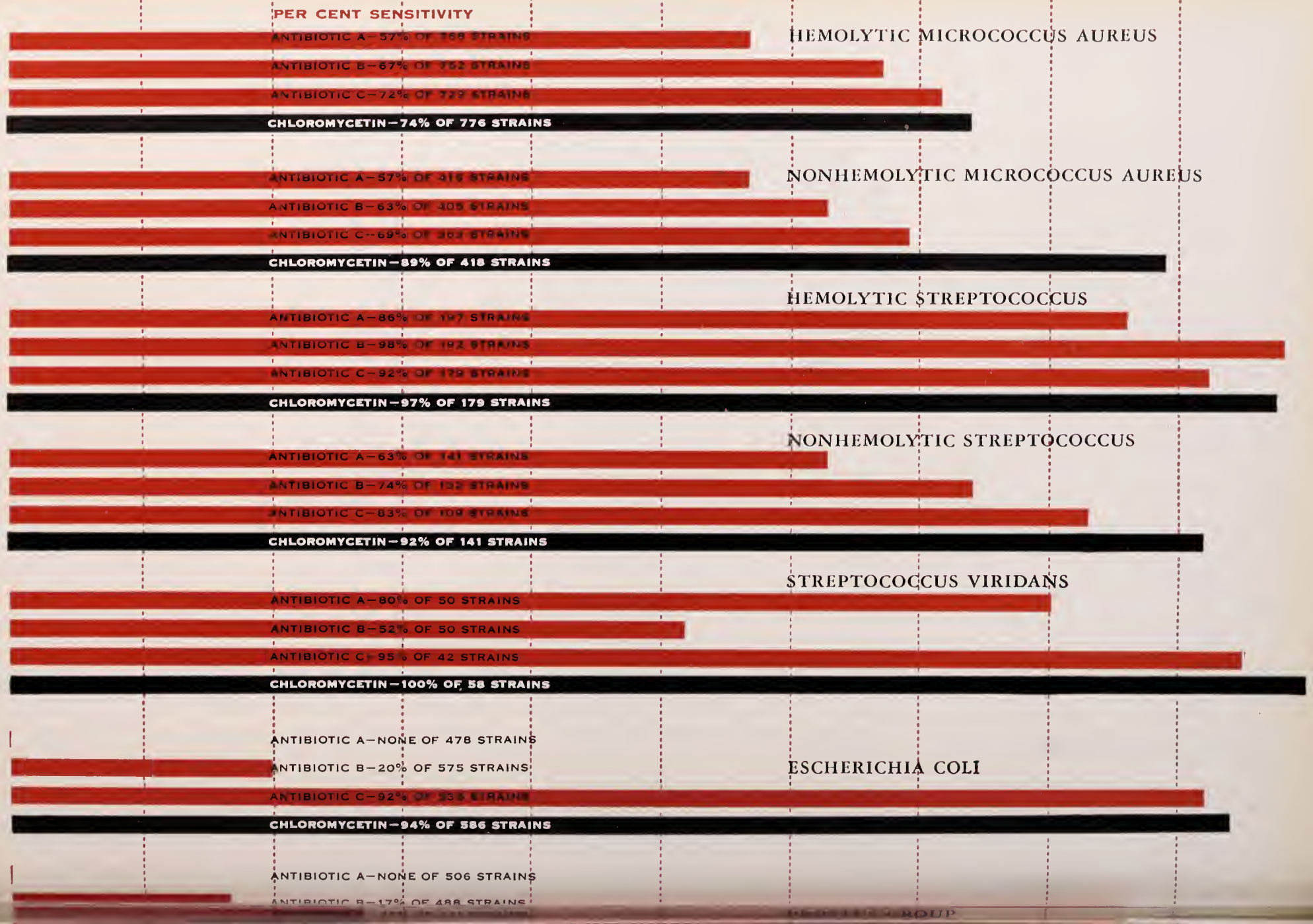
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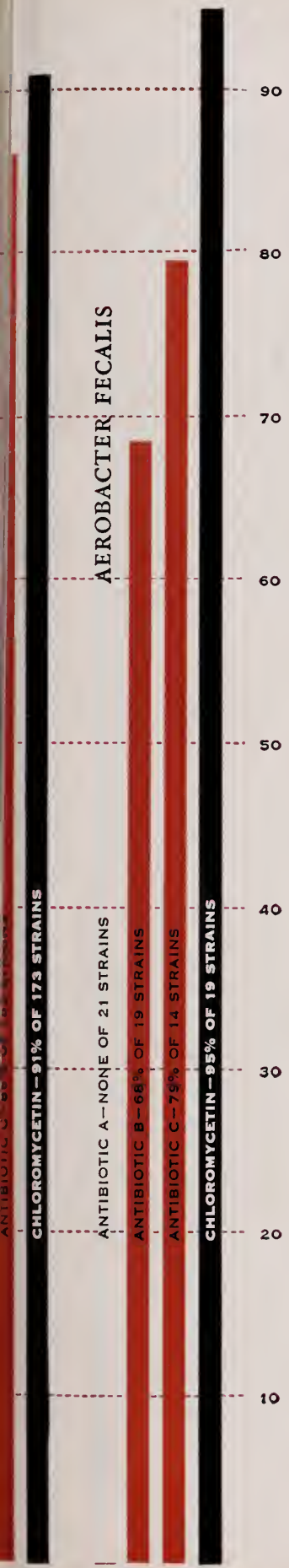
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1. McKenna, R.D.: Royal Victoria Hospital, Montreal, Canada: Personal communication.
2. Ingegno, A.P.; and Kertzner, Leonard: New York Jour. Med., 54:1185, Apr. 15, 1954.

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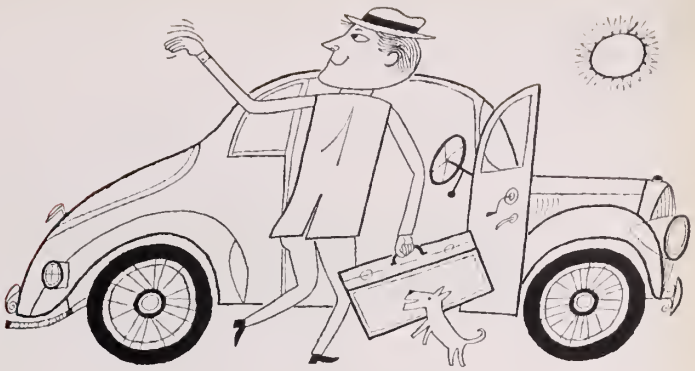
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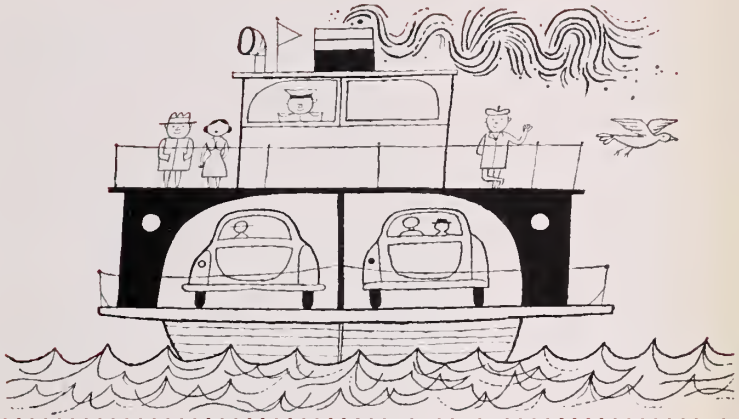
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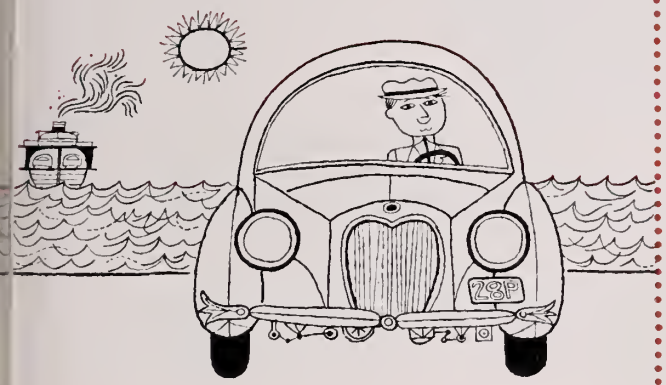
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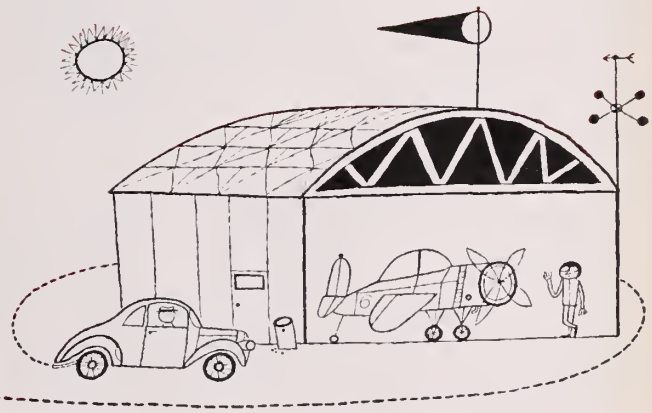






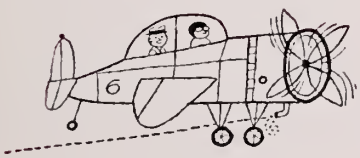






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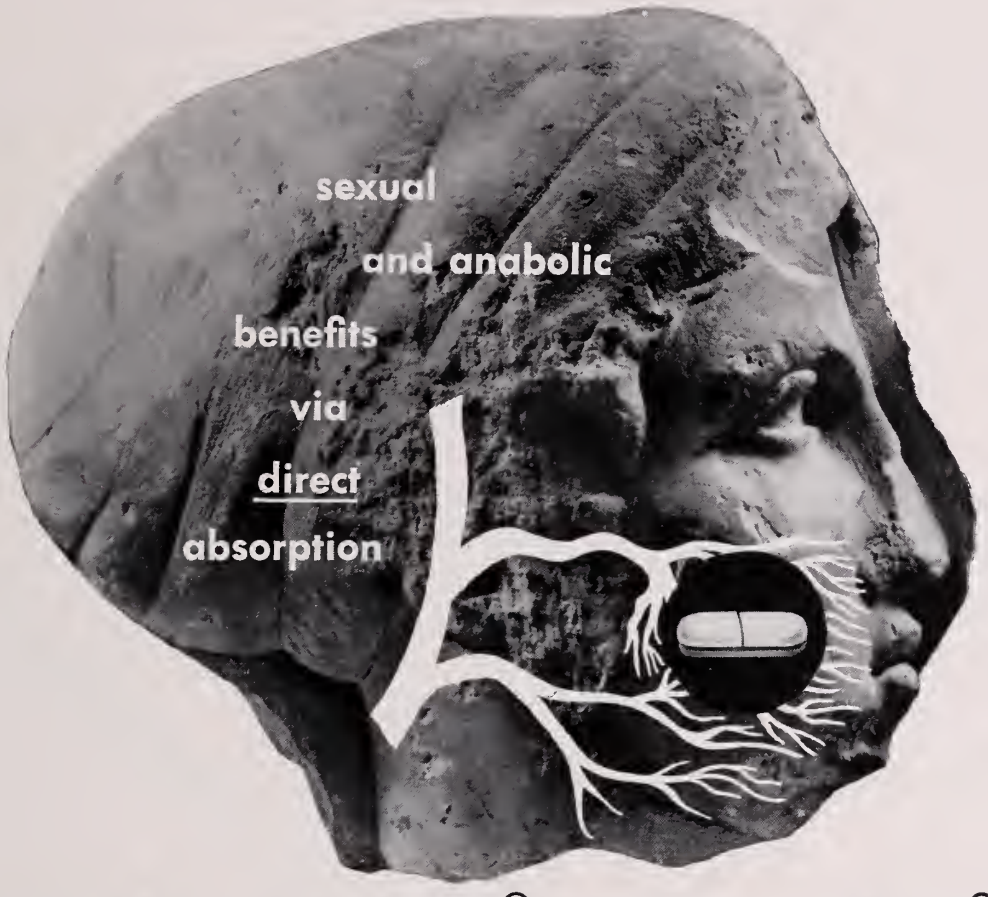
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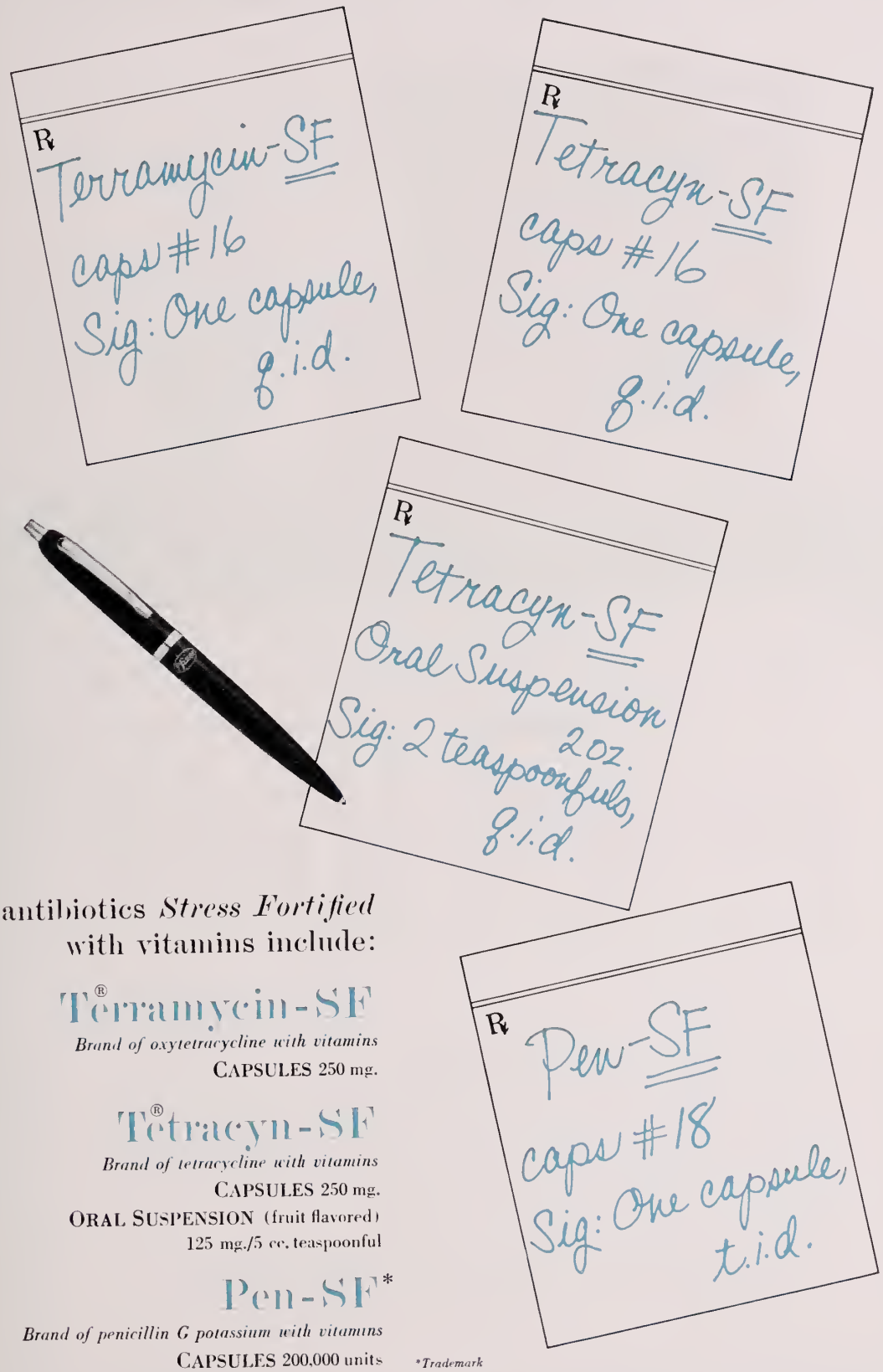
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THE PATHOGENESIS OF ASCITES AND A CONSIDERATION OF PRE-EXISTING PORTACAVAL SHUNTS IN CIRRHOSIS AND METASTATIC CARCINOMA*

JOHN M. LORÉ, JR., M.D.

The Author. *John M. Loré, Jr., M.D., of New York City. Member, Surgical Staff, Department of Surgery, St. Clare's Hospital, New York.*

In 1950, Dr. John L. Madden, Director of Surgery at St. Clare's Hospital, was particularly interested in the anatomy of the portal vein in relation to the pancreas during radical pancreaticoduodenectomy for carcinoma of the head of the pancreas. Stimulated by the work of Tobin and Zariquiey[1] who demonstrated the anatomy of the bronchopulmonary segments and blood supply of the human lung using liquid latex, we began a study of the surgical anatomy of the portal system. Our co-worker in this endeavor was Dr. Frank P. Gerold.

Material and Methods

Fresh cadaver specimens were injected with colored liquid neoprene latex (Type 571†) partially fixed in Jores' solution No. 1, then dissected and photographed. Some of the specimens were subsequently corroded in commercial hydrochloric acid. Red latex was injected into the arterial system; yellow into the portal venous system; and blue into the caval or systemic venous system. In the first few specimens, yellow latex was not used. The primary colors of yellow and blue (the portal and systemic venous systems respectively) when mixed formed a green or chartreuse color indicating portasystemic communications.

Discussion

It is generally accepted that the cause of ascites in cirrhosis of the liver is primarily an intrahepatic portal bed block. This blockage of the inflow tract of the liver, an obliterative fibrosis of the intrahepatic portal bed, is considered to be the primary cause of portal hypertension. It is felt that the production of some type of portacaval shunt is the treatment of choice for the sequelae, viz., bleeding esophageal varices and ascites. The picture, we believe, is not so simple nor is this concept consistent with clinical and experimental observations.

The ligation of the portal vein in the Macaca Mulatta monkey and man as shown by Child, McClure and Hays[2] fails to produce ascites. Lower, in 1728,[3] and Bolton, in 1909 and 1915,[4] produced ascites by ligation of the thoracic segment of the inferior vena cava. The latter suggested the role of the hepatic veins in the production of ascites. In the Budd-Chiari syndrome, which always is associated with ascites, there is thrombosis of the hepatic veins, the outflow tract of the liver. These observations point to the fact that if the inflow tract is blocked, there is no ascites; whereas, if the outflow tract is blocked, there is ascites.

Experimental findings which are to be presented to you will substantiate our postulate that the pathogenesis of ascites in cirrhosis of the liver is due to a primary diffuse blockage of the intrahepatic systemic venous bed, the outflow tract, and not a primary blockage of the intrahepatic portal bed, the inflow tract. Our findings do not substantiate the present concept of intrahepatic portal bed fibrosis in cirrhosis of the liver associated with ascites. There actually is an increase in the intrahepatic portal bed and a decrease in the intrahepatic systemic venous bed in the presence of ascites. True, the portal system is blocked, but merely secondarily. Just as you may be delayed in a long line of slow-moving automobiles, the vehicle immediately before you is not the primary cause of your delayed progress but rather the automobile up ahead which is blocking the exit is the primary cause; and so it is in cirrhosis. The trouble maker is the blockage at the exit—namely, the hepatic veins.

In England, Aterman[5] has shown that carbon tetrachloride absorbed by rats causes cirrhosis of the liver and ascites. The resulting microscopic pic-

continued on next page

*Presented at the meeting of the Providence Medical Association, at Providence, Rhode Island, February 7, 1955.

From the Surgical Research Laboratory and the Department of Surgery, St. Clare's Hospital, New York, New York.

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ture is an obliterative fibrosis of the hepatic radicals and not the portal radicals. Why the selectivity for the hepatic radicals? I do not know. And how did the present concept of portal fibrosis as the cause of ascites become so deeply rooted in the literature? It is difficult to say. Herrick, in 1907,[6] showed in perfusion experiments of normal and cirrhotic livers (he neglected to state the presence or absence of ascites) that gram for gram the cirrhotic had a larger portal vascular bed. McIndoe[7] in his injection experiments showed a decrease of both the portal and hepatic vascular beds, and indicated that the degree of fibrosis varied in direct ratio to the severity of the disease process. The exact correlation of his specimens with cirrhosis to the presence or absence of ascites is not clear. Although the findings of Herrick and McIndoe appear to be contradictory at first analysis, Herrick may have used specimens which had irreversible ascites, in which we have demonstrated there is an increase in the intrahepatic portal bed, while McIndoe may have used specimens which had functional or reversible ascites in which we have demonstrated that there is a symmetrical decrease in both intrahepatic venous systems. This would indicate that both of their observations were genuine and correct.

Observations

In the normal liver there was observed a uniformity in the pattern of the intrahepatic circulation. The tributaries of the portal and hepatic veins, and the branches of the hepatic artery, were in constant equilibrium. The hepatic artery and its branches were closely related to the portal vein and its tributaries. The hepatic veins appeared as isolated areas (blue) but uniform in their distribution throughout the liver and in their relation to both the hepatic artery and the portal vein. Free intrahepatic communications between the portal vein (yellow) and the hepatic veins (blue) were depicted by the appearance of a chartreuse color indicating an admixture of the two primary colors, yellow (portal system) and blue (hepatic veins).

In cirrhosis of the liver the pattern of the intrahepatic circulation was dependent upon the presence or absence of ascites and whether or not the ascites was reversible or irreversible. In cirrhosis of the liver with irreversible ascites there was a reciprocal pattern of the circulation within the liver characterized by an absolute and compensatory increase in both the intrahepatic portal venous and the hepatic arterial beds, the inflow tracts, and a concomitant and absolute decrease in the outflow tract, the hepatic systemic venous bed. Contrariwise, in cirrhosis of the liver without ascites, or with ascites that was temporary or reversible, there was a symmetrical pattern relationship characterized by a symmetrical deficit in all of the intrahepatic vascular systems but most pronounced in the hepatic systemic and portal venous beds.

In congestive hepatomegaly, one with and one without ascites, there was a distinctive pattern of the intrahepatic circulation characterized by a marked increase in both the diameter and the surface area of the hepatic systemic venous bed, the outflow tract. There was no concomitant changes evident in the inflow tracts, viz. the portal venous or hepatic arterial beds.

Further experimental work was then performed in our animal laboratory. Partial ligation of the hepatic veins was performed in fifteen dogs. Of the ten survivors, seven (70 per cent) resulted in the formation of ascites clinically varying from mild to severe. The duration of ascites varied from ten to forty-seven days. After the ascites disappeared, two dogs were subsequently placed on a low protein and high-salt diet. The ascites promptly recurred and in one dog the ascites has been present for some twelve months. The liver is two fingers below the costal margin and very firm. These animals periodically and spontaneously drain ascitic fluid from the abdominal incision.

In another animal all the hepatic veins draining the right lobes and caudate lobe of the liver were completely ligated. These lobes immediately appeared congested and enlarged and six weeks later they were contracted and slightly irregular. Microscopic slides showed evidence of early cirrhosis. These experimental studies directly indite the hepatic veins as a primary factor in the production of ascites. Diet also is a factor when there is preexisting hepatic vein obstruction. The rationale of proper medical regimen in reversible ascites appears well-founded. On the other hand, in ascites refractory to a medical regimen, the surgical treatment should be directed to the establishment of a new outflow tract of the liver. The feasibility of this concept is being evaluated at the present time in our laboratories by the use of hepatopexy[8] — namely, the abrasion of the liver surface and the juxtaposed surface of the diaphragm. Magnesium trisilicate powder, after the method of Thompson,[9] is applied to the abraded surfaces. Abdominal flaps consisting of muscle, fascia and skin which have been raised and swung intra-abdominally and then attached to the liver surface are also being evaluated.

Comment

From the study of the anatomic pattern of the intrahepatic circulation in the normal and in the diseased human liver, certain postulates relative to the pathogenesis and the treatment of ascites secondary to cirrhosis of the liver may be presented. It is postulated that the pathogenesis of ascites in cirrhosis of the liver is an obstruction of the out-

flow tract, the hepatic systemic venous bed. In chronic, irreversible ascites the cause of the obstruction is believed to be an obliterative fibrosis. This is an organic occlusion and, accordingly, is refractory to all of the generally accepted methods of treatment. In acute, temporary or reversible ascites, the obstruction of the outflow tract is due to a diffuse intrahepatic cellular edema secondary to both protein and electrolyte imbalance. In this instance the obstruction is functional and, accordingly, with proper diet and medication, the intrahepatic cellular edema subsides, the obstruction of the outflow tract (hepatic veins) is released and the congestive hepatomegaly and the ascites disappear. This postulate would conform with the clinical observation of the poor prognosis in patients with cirrhosis of the liver and ascites in whom the liver is small and contracted (obliterative fibrosis of the outflow tract) and the more favorable prognosis in patients with cirrhosis of the liver and ascites in whom the liver is acutely enlarged (edematous or functional obstruction of the outflow tract).

In congestive heart failure and in chronic constrictive pericarditis the pathogenesis of the ascites is again obstruction of the outflow tract, the hepatic veins. The obstruction is due to venous stasis with secondary intrahepatic cellular edema and congestive hepatomegaly.

Natural Occurring Portacaval Shunts

The next consideration is that of the high incidence of natural occurring or pre-existing portacaval shunts. In two specimens without liver disease, two large shunt veins were found—one measuring four millimeters and the other three millimeters at their narrowest diameters. One extended from the fundus of the stomach to the left adrenal vein; another from the mesenteric veins of the terminal ileum to the right ovarian vein.

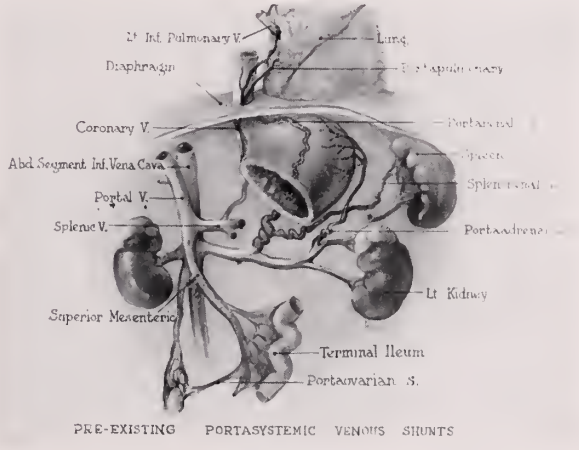
In other specimens with cirrhosis other shunts were found. In two specimens, two vessels each larger than three millimeters in diameter extended from the lower third of the esophagus and cardiac end of the stomach to the left inferior pulmonary vein. These vessels establish direct communications between the cardio-esophageal veins and the pulmonary circuit. Yellow latex was found in the lung. In another specimen a large torturous shunt vein extended from the cardiac end of the stomach to the left renal vein with an accessory vessel from the spleen. In still another specimen yellow latex was seen communicating with the left adrenal gland. It is noteworthy that all of these patients expired from bleeding varices. All except one had ascites of varying degrees.

What effect do these natural occurring shunts have on the cirrhotic patient? Learmonth,[10] while preparing to do a splenorenal shunt in a patient with cirrhosis who was bleeding from varices, discovered a natural six millimeter in diameter splenorenal shunt. Apparently, despite these natural shunts, patients bleed to death from varices. It is impossible at the present time to state definitely whether their lives are prolonged or shortened by these shunts. However, the portapulmonary shunts could conceivably be a detriment during an increase in intrathoracic pressure as in a Valsalva maneuver. Any sudden increase in systemic pressure could cause a blowout at the site of the portacaval communication as might occur when straining at stool. There are no adequate figures of comparable survivors of patients with surgically produced portacaval shunts as compared with cirrhotics not so treated.[11] Another stumbling block in this evaluation is now the realization of natural occurring portacaval shunts. From this small series of patients who bled to death despite the presence of preexisting shunts, the performance of portacaval anastomosis appears interdicted. Inasmuch as varices are seen in one of our specimens not only in the cardioesophageal region but also in the jejunum and terminal ileum, the direct surgical attack upon the cardioesophageal varices seems questionable.

Apart from the patient with cirrhosis of the liver, these natural occurring portacaval shunts are of definite interest in the explanation of some of the bizarre metastasis of carcinoma.

The spread of Krukenberg tumors from the stomach and other portions of the gastrointestinal

concluded on page 264



PRE-EXISTING PORTASYSTEMIC VENOUS SHUNTS

FIGURE 1

Composite drawing to show the pre-existing portacaval shunts. The shunt between the fundus of the stomach and the left adrenal vein and the shunt between the mesenteric veins of the terminal ileum and the right ovarian vein were found in patients without evidence of liver disease. Such shunts can explain the spread of Krukenberg tumors to the ovary and other tumors to the adrenal gland. All the other shunts were found in patients with cirrhosis of the liver. All these patients despite the shunts had hematemesis and expired.

MODERN ATTACK ON PULMONARY TUBERCULOSIS

WILLIAM B. O'BRIEN, M.D., ORLANDO ARMADA, M.D., and NORMAN J. WILSON, M.D.

The Authors. *William B. O'Brien, M.D., Superintendent; Orlando Armada, M.D., Resident Physician; and Norman J. Wilson, M.D., Surgical Consultant, all of the Rhode Island State Sanatorium, Wallum Lake, Rhode Island.*

IN RECENT YEARS there has been a complete change in the treatment of pulmonary tuberculosis. Actually this dates from the introduction of streptomycin for widespread use in 1947. Today we have arrived at a definite idea in the prolonged uninterrupted drug therapy made possible when para-amino-salicylic acid came on the scene in 1949, followed by isoniazid in 1951, and later pyrazinamide. Combinations of these antimicrobial drugs have been able to control most of the minimal and early moderately advanced lesions. Moreover they have proved effective in controlling any toxicity, in reducing secretions, and in improving the patient in general. Following this, even though cavity or areas of caseation persists the patient is now ready for definitive treatment by thoracic surgery.[1]

All surgical procedures have been made safer by the preliminary course of drugs and additional protection is offered at the time of surgery by these same drugs. Coupling this with improved anesthesia, and the experience of the thoracic surgeons, we have had a tremendous boom in all forms of chest surgery, especially resection. In our hands permanent collapse, such as afforded by extraperiosteal plombage techniques has achieved considerable favor because of its results. We have completely abandoned phrenic nerve paralysis and pneumothorax, but we still use pneumoperitoneum to a fair degree. Drug therapy alone has supplanted these procedures in the treatment of early exudative disease and small cavities. Anything beyond this is better treated by surgery especially when irreversible pathological changes have occurred.

We are discussing in this paper the results achieved at the Rhode Island State Sanatorium during the drug era between January 1947 and January 1954. We are referring only to the 411 unilateral surgical problems. Eighty patients treated with bilateral surgery will not be discussed because they are too complex for analysis, since different procedures were used on each side in most cases.

The status of these 411 patients was evaluated in July 1954, thus offering a minimum of six months and a maximum of 7½ years of observation following completion of surgery. Of these, 260 were followed for at least two and one-half years, and 335 for at least one and one-half years.

The only true contraindication to surgery that we recognize at any time are:

1. Inadequate cardiac reserve.
2. Inadequate respiratory function to withstand the proposed procedure.
3. The existence of another disease process which is either uncontrollable or has a fatal prognosis.

Diabetes is not a contraindication. On the contrary we know that the prompt control of both the diabetes and the tuberculosis is essential. We use surgery in a high percentage of the diabetics and we get them to surgery as soon as possible.

Age alone is not a contraindication. Many of our patients are over sixty years of age at the time of operation, and in this day and age patients in the fifties are very common. We feel that as long as they pass our requirements they should be operated on and the proof of this is that they have tolerated surgery of all types remarkably well. We do not subscribe to any theory that an elderly patient with an open cavity should exist as a "good chronic." We do not feel that it is fair to keep these individuals in institutions separated from their friends and from their families. We feel they should be returned to the community, and in many instances to their former jobs.

Until recently we had been using stage thoracoplasty as the chief instrument in collapse therapy. This will be referred to hereafter as conventional thoracoplasty. We felt it had several disadvantages in that it caused the patient to go through several phases of physical and mental strain. It also increased the cost of surgery, and limited the number

From the Rhode Island State Sanatorium and the Overholt Thoracic Clinic, Boston, Massachusetts.

[1] Thoracic surgery performed by Dr. Norman J. Wilson, Overholt Thoracic Clinic.

of patients who could be treated in a given period. The conversion of sputum was very slow. Frequently, paradoxical motion of the chest interfered with respiration and cough mechanism. Most important of all, deformity resulted from scoliosis due to abnormal position of the shoulder girdle caused by cutting the first rib and the transverse processes of the spine.

Accordingly, in 1950, we gave up conventional thoracoplasty, as such, in favor of plombage procedures. We still use a conventional thoracoplasty from below up, which preserves the first rib, but this is only used once in a while for special indications.

The extraperiosteal plombage technique was first performed in this hospital in 1949. It has been our experience that it is one of the safest and most effective measures of collapse procedure. It is used in treating small cavities in the top of superior segments of upper lobes. The entire collapse is created in one operation. The number of ribs and the length of ribs stripped of periosteum, below the first rib which is stripped entirely, depends upon the extent and distribution of the lesion. The operation is designed to compress only diseased areas and to avoid collapse of normal segments of the lung. As many as eight ribs may be stripped at one operation without any evidence of shock in the patient. The ribs are now left intact and the extraperiosteal space packed with one and one-quarter inch lucite spheres inside a polyethylene wrapping. This is done to prevent the spheres from migrating out between the ribs and also to make their removal easier at a later date. More recently we have not been using the lucite spheres at all but have packed the space firmly with the polyethylene sheeting alone wrapped inside of one large piece of the material.

One week following operation all drugs are stopped unless active endo-bronchial disease, or tuberculosis in the opposite lung, indicates their use. It is only in this way that early collapse failure can be determined because if drugs are continued sputum might well remain negative even though disease is uncontrolled. After four months of careful sputum study, a decision as to further surgery is made. With sputum negative a second stage is performed removing plombage and resecting the ribs. The first rib and the transverse processes in the spine are left intact to avoid deformity. If sputum remains positive resections of the affected segments is performed and the second stage of the thoracoplasty completed at the same time. Thus, either way the patient's course consists of a maximum of two operations.

In patients over fifty-five years of age we have been leaving the plombage intact with no second stage whatsoever. We have had no reason to feel that the plombage material will cause any complications. It is possible that we may have to change our mind on this as time goes on. We have had only one infection in the extraperiosteal space which occurred early in the use of the procedure and probably was due to a technical error when the extrapleural space was inadvertently opened.

The chief advantages of plombage thoracoplasty are—total collapse is secured in one stage. Sputum is converted to negative early. There is no paradoxical motion of the chest and hence no interference with respiration and cough. There is less strain on the patient, and there is less cost for the surgery, and more surgery can be done in one given period of time. There is no significant deformity of the chest which occurs, even though the X-ray may show a slight scoliosis. The loss of function as determined by pulmonary ventilatory studies is small and is more predictable. Also failures can be treated early with resection and still only have a total of two operations. We consider this the safest surgical procedure in the treatment of pulmonary tuberculosis.

We have had no deaths due to tuberculous infection in this group of 140 patients. Of the three who died; two suffered coronary occlusions, and one had a metastatic carcinoma. 137 (97.8%) are living and of these, 127 (92.7%) are completely cured. Our results with this procedure have been so uniformly good that we have not shifted completely to resection as many other clinics have done.

In cases treated by all methods of collapse therapy surgically induced 98% of the patients are living and 93% are completely well.

In the drug era resection has increased to a point where it is now the most commonly used method of treatment in pulmonary tuberculosis. Particularly prominent is the use of segmental resection. It appeals equally to the medical men, the surgeon, and the patient since it permits eradication of an offending lesion with preservation of maximum normal lung tissue. Again it must be emphasized that in many instances other tuberculosis which was present has been brought under control by drugs.

The indications for resection in general are: 1) thoracoplasty failure, 2) bronchial stenosis, 3) tuberculoma, 4) uncontrolled lower lobe disease, 5) bronchiectasis, 6) associated suppuration, and finally 7) cavity in a non-expansile lung with or without associated empyema following pneumothorax.

Cases which do particularly well are those with giant cavities which are under tension and with poor drainage. Cavities in poor position for collapse such as those near the mediastinum, and cavities in the anterior segment of the upper lobes or lying completely posteriorly in the upper lobe so that large volumes of normal lungs must be sacri-

continued on next page

ficed in collapse therapy.

A severe problem which has arisen as a result of drug therapy is which residual lesions should be resected. A negative sputum is no longer a good index because of the action of the drug. Our present X-ray technique, even body section X-ray, are not completely reliable. The smaller residual areas are now being treated medically. The larger areas of caseation are resected as well as any cavity.

The mortality rates for pneumonectomy or lobectomy plus segmental resection are higher in the resection group because they are the worst cases to begin with.

Thirteen of the 174 resections had tuberculous complications. This is 7.5% of the cases. These were subsequently controlled with additional surgery and or drug therapy.

Twenty, or 11.5%, had late tuberculous complications which were subsequently brought under control.

There were 5, or 2.9%, post-operative deaths caused by: fistula and spread 1; pulmonary edema 1; pulmonary insufficiency 1; pulmonary embolus 1; blood dyscrasia 1.

There were 8, or 4.6%, late deaths caused by: coronary occlusion 1; cor pulmonale 3; fatal hemorrhage from empyema space 1; progressive tuberculosis 2; leukemoid metaplasia 1.

One hundred and sixty-one, or 92.5%, of the 174 patients are alive and 151, or 94%, of these are clinically well. Fifty percent of the patients were operated on prior to January 1952 before we were using long term chemotherapy.

As was mentioned we are depending more and more upon careful ventilatory study of pulmonary function in the appraisal of a patient in any given surgical procedure.

The aim of any particular surgical procedure in the treatment of pulmonary tuberculosis is not only the cure of the patient but the preservation of as much of the patient's cardio-respiratory ability as possible, in order that the patient will not become a respiratory cripple. Thus, the decision to operate may be based by the determination of the patient's pulmonary function and the choice of the surgical procedure should be determined by the results of these tests. The more restricted a patient's respiratory reserve, the more essential it is to know the type of restriction and its extent.

The patient's ability to withstand a particular surgical procedure can be determined:—

(a) by clinical judgment, observation of breathing, cyanosis, shape of the chest, speed with which the chest can be emptied (fluoroscopy), and the examination of roentgenograms.

(b) by performing some of the ventilatory function measurements—vital capacity and better still, the Timed Vital Capacity (V.C.); Maximum Breathing Capacity (M.B.C.) which is the ability to pump air into and out of the lungs in a specified time. At this time it is important to stress the fact that the dyspnoea is more closely related to reduction in M.B.C. than to V.C. When M.B.C. is high, the reserve is obviously adequate. When the M.B.C. is below 35 liters per minute, surgical procedure is not advisable. On the other hand, when M.B.C. is reduced, the removal of a destroyed or poorly functioning lung or lobe is well tolerated.

(c) by the technique of bronchospirometry.[2] With this method, knowledge is obtained of the degree to which each lung participates in respiration (a split function). This method is useful and essential in borderline cases, especially in those in which bilateral surgery is contemplated. The preliminary studies mentioned in (a) and (b) should be performed prior to bronchospirometry because some patients show such poor respiratory reserve with these tests, that plan for surgery must be abandoned. On the other hand, some patients show such excellent pulmonary reserve with these studies (a) and (b), that almost any planned surgical program can be undertaken without the knowledge of the result of a split function.

The following cases listed below will illustrate these points:—

Case #1—G.G., male, fifty-two years of age, had a residual cavity in the right upper lobe, the remainder of X ray is clear. Plombage thoracoplasty con-

[2] Bronchospirometric studies by Dr. David W. Cugell, Boston Sanatorium, Mattapan, Mass.



FIGURE 1

Case No. 1 G.G. Prior to right extraperiosteal plombage.

templated. Fluoroscopy shows good movement of diaphragms and good speed of emptying. Prior to surgery, predicted V.C. 3,600 c.c.; Actual V.C. 3,150—87% of predicted; Predicted M.B.C. 100; Actual M.B.C. 94—94% of predicted. No bronchospirometry indicated in this case. After 5 rib extraperiosteal plombage, (2 stages), V.C. 3,150; M.B.C. 84. There was a loss of 10 liters and this is our average loss of function with 5 rib extraperiosteal plombage.



FIGURE 2

Case No. 1. G.G. Following first stage right extraperiosteal plombage.



FIGURE 3

Case No. 1. G.G. Following second stage right extraperiosteal plombage.

Case #2—S.M., female, twenty-seven years of age with bilateral cavitation involving the upper lobe. Bilateral surgery contemplated. Fluoroscopy shows poor emptying of the lungs. Predicted V.C. 3,100; Actual V.C. 1,350—40% of predicted; Predicted M.B.C. 91; Actual M.B.C. 53—58% of predicted. Bronchospirometry was performed in this case.

O_2 Uptake	Rt. lung	42%
	Left lung	58%
Ventilation	Rt. lung	41%
	Left lung	59%

Obviously, this patient was an exceedingly poor risk for any surgical program and the idea of surgery was abandoned. Patient died shortly after with pulmonary insufficiency and "cor pulmonale."



FIGURE 4

Case No. 2. S.M. Prior to bronchospirometry studies.

Case #3—G.H., female, thirty-seven years of age; extensive involvement with several areas of cavitation in the left lung. Right lung was clear. Left pneumonectomy contemplated. Fluoroscopy showed good function of the right lung and the left lung was almost functionless. Predicted V.C. 3,060; Actual V.C. 2,030—66% of predicted; Predicted M.B.C. 93; Actual M.B.C. 65—70% of predicted. Bronchospirometry was performed.

O_2 Uptake	Rt. lung	100%
	Left lung	0%
Ventilation	Rt. lung	92%
	Left lung	8%

concluded on next page



FIGURE 5

Case No. 3. G.H. Prior to left pneumonectomy.

Left pneumonectomy was performed on this patient and was very successful.

SUMMARY

The advent of the anti-tuberculous compounds has resulted in a complete change in the treatment of pulmonary tuberculosis. Resection is now the most frequently used procedure. Nevertheless our figures indicate that the prognosis for a given patient depends chiefly on the control of the open lesion rather than on the type of surgery which is employed. This fact is demonstrated in that about 95% of all our living patients treated by various surgical methods are completely well. In our hands a lesion adequately controlled by collapse procedure has an equally good prognosis with one which has been resected. The secret to successful surgical treatment of pulmonary tuberculosis lies in the selection of the most simple and safest procedure which will permanently control the disease.

PATHOGENESIS OF ASCITES

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tract to the ovary may be explained by such a portaovarian shunt as was found in one of our specimens. The latex injected into the portal system promptly filled the veins of the right ovary. The selective spread of carcinoma of the gastrointestinal tract to the adrenals as well as lung to adrenals may be explained by the portapulmonary and portaadrenal shunts.[12] These portapulmonary shunts may also account for metastasis from gastrointestinal malignancy directly to the lung, bypassing the liver. These possibilities and others of metastatic spread have been of particular interest to Pack, Deddish, Gerold, and Brasfield.[13]

Conclusions

It is postulated that the primary factor in the formation of ascites is an obstruction of the outflow tract of the liver — namely, the hepatic veins.

It is believed that there is a high incidence of natural occurring portacaval shunts. These shunts may either be a benefit or a detriment to the patient with cirrhosis of the liver. These shunts are offered as an explanation for some of the otherwise unusual metastases of intraabdominal and intrathoracic malignancies.

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PATRONIZE JOURNAL ADVERTISERS

TREATMENT OF ACUTE INFECTIOUS MENINGITIS IN A GENERAL HOSPITAL*

EARL F. KELLY, M.D., HRAD ZOLMIAN, M.D., AND BANICE FEINBERG, M.D.

Introduction

Earl F. Kelly, M.D., Pediatrician-in-Chief; Chairman, Executive Committee, Pawtucket Memorial Hospital.

THE PURPOSE in presenting this topic for discussion is twofold. One, because the changing patterns in the treatment of acute infectious meningitis have been rapid over the past ten years, resulting in a greater reduction of mortality and the prevention of complications and sequelae, brought about with the use of the many new antibiotics available, and the wonderful results obtained.

The second reason for this presentation is to show that it has been an accepted fact that any communicable disease should, and can, be handled effectively in a small general hospital like the Pawtucket Memorial, if regular and proper precautions are carried out. The treatment of these cases has been carried out in this hospital in the Pediatric Department for twenty-five years. It has been stated by the American Academy pediatric committee on hospital procedures and technique that a general hospital in a community such as ours is not worthy of being called a good hospital if it has not the staff and the equipment available for the treatment in such an institution.

The first presentation, by Dr. Hrad Zolmian, shows the type of cases seen in the Pawtucket Memorial hospital, together with some interesting statistics illustrating the changing pattern in treatment and the changing trend in the type of acute infectious meningitis that we are getting in our Pediatric Department in the present day.

The second presentation, by Dr. Banice Feinberg, discusses briefly the treatment of the various types, and the latest treatment of choice, as well as the type of cases we have had in the department with the specific treatment given.

Meningitis in Children

Hrad H. Zolmian, M.D., Senior Assistant Pediatrician, Pawtucket Memorial Hospital.

Acute Purulent Meningitis in children has been handled by the Pawtucket Memorial Hospital through the years and has included all types. We feel, therefore, that a short review of its cases is in order.

In the past ten years out of seventy cases these have been in order of frequency those caused by influenza, meningococcus, tuberculosis, pneumococcus, streptococcus, staphylococcus, and some types undiagnosed. Influenza has accounted for 20 or 28%, meningococcus 20 or 28%, tuberculosis 6 or 8%, pneumococcus 7 or 10%, and streptococcus 3 or 4%, and types undiagnosed 12 or 17%.

Distribution of Cases

Meningococcus	20	28%
Influenza	20	28%
Tuberculosis	6	8%
Pneumococcus	7	10%
Streptococcus	3	4%
Staphylococcus	1	1
Type Undiagnosed	12	17%

There are interesting changes in the distribution of cases and associated vital statistics. Since the advent of more antibiotics these changes show up quite sharply. Therefore, I would like to divide the cases into an early period, 1944-49, which includes 40 cases, and a recent period, 1950-54, which includes 30 cases.

	1944-49		1950-54	
	40 cases		30 cases	
Influenza	6	15%	14	46%
Meningococcus	15	37%	5	17%
Tuberculosis	5		1	
Pneumococcus	4		3	

Although the total number shows an equal number of influenza and meningcoccus, separating the records by years reveals a predominance of meningococcus in the early group and a predominance of influenza in the recent group. In the early group out of 40 cases, meningococcus accounts for 15 or 37% and influenza for 6 or 15% of those cases. In the recent group of 30 cases meningococcus has fallen to 5 or 17% and influenza has risen to 14 or 46% of the cases in these years, practically a complete reversal. In the later group pneumococcus runs ahead of tuberculosis 3 to 1. Otherwise this distribution compares approximately with reports of the authorities. Dr. Burdick at a recent symposium on infectious diseases in Providence listed

continued on next page

*Presented at the John F. Kenney Clinic of the Pawtucket Memorial Hospital Internes' Alumni Association, November 3, 1954.

influenza, meningococcus, and tuberculosis in order of frequency. We may conjecture whether these changes with relatively fewer cases of meningococcus, greater numbers of influenza, and much reduced tuberculosis indicate changes in the virulence and prevalence of organisms of this community and whether they are the results of the increased use of antibiotics.

The ages of influenza meningitis cases have ranged from 1-10 years, meningococcus from 5 weeks-15 years. Again the two main groups were quite different if separated into an early and recent group.

Age Groups

	1944-49	1950-54
Influenza	1 year	6 mos.-10 yrs.
Meningococcus	5 wks.-3 yrs.	8-15 years
Tuberculosis	1½-3 years 1 at 9 years	
Pneumococcus	3 months-7 years	

Influenza cases in the early group were all 1 year of age, a few weeks more or less, meningococcus 5 weeks to 3 years. Older individuals join them in the recent group, influenza 6 months to 10 years (and influenza predominated in the recent group), meningococcus 8-15 years.

Another remarkable and quite extreme change is in that of mortality.

Deaths

1944-54 70 cases	16	23%
1944-49 40 cases	15	38%
1950-54 30 cases	1	3%

Altogether in 10 years there were 16 or 23% deaths. However, this was mostly in the early group when there were 15 or 38% deaths. Of these, by the way, all except 4 were a few hour to 1 day stays before death of moribund or fulminating cases. These, also, included 1 associated with a brain abscess and a larger proportion of the tuberculosis cases. The recent group has fallen to 1 or 3% mortality. This was a meningococcus case of the Waterhouse-Fridrichsen type. There were no influenzal deaths in our recent group. Present reports show that influenzal deaths have fallen generally from 90% to less than 10%. We may state more certainly, I believe, that this great reduction is due to the addition of newer antibiotics to our armamentarium.

Hospital Stay

Recovered Cases (except for below)	2-2½ weeks
Dead (except for below)	1 day
Brain Abscess	32 days
Tuberculous (6 cases)	12-68 days

Average stay in the hospital of the recovered cases was in the majority of cases 2-2½ weeks, a reduction of several weeks over the past. This compares with experiences elsewhere. Of the deaths most were, as stated before, stays of 1 day or less. One brain abscess spent 32 days, 3 tuberculous cases spent 12, 23, and 68 days. The last case of tuberculous meningitis was in 1950. This was treated altogether for 1½ years partly elsewhere with final recovery.

The number of lumbar punctures done per case, except for the long cases, were approximately 2-3. One tuberculous case in 1945 had almost a daily one for 2 months, quite a therapeutic problem.

Keeping pace with the introduction of antibiotics treatment has, also, undergone changes. All of these cases have been treated with Sulfadiazin, Sulfadiazin alone in the early group and Sulfadiazin with antibiotics in the recent group.

Treatment

1944-49	Sulfadiazin
1945-	Sulfadiazin + Streptomycin
1950-54	Sulfadiazin + Chloromycetin
	Sulfadiazin + Aureomycin
	Sulfadiazin + Terramycin
Lumbar Punctures	2-3 per case

The first case of tuberculous meningitis treated with Streptomycin in Rhode Island was treated in July 1945. Shortly afterward another was treated with Streptomycin for 68 days (the case cited above), 0.6 gm. IM. daily and for almost all of the same period streptomycin intrathecally daily 0.25 gm. This had followed a previous miliary tuberculosis and tuberculous otitis which had cleared of that admission. The total cost of streptomycin in this case was over $2000. Again the change from sulfadiazin alone to the addition of broad spectrum antibiotics seems to coincide definitely with the various changes from the early to the late group.

From the foregoing outline there is evident a marked redistribution in the types and ages of meningitis in the Pawtucket Memorial Hospital and an even more marked reduction in the death rate, hospital stay, and treatment. This compares favorably with present day experience of other institutions. It indicates, I believe, that this, representing the community general hospital, may care adequately, as well as specialized centers, for Acute Infectious Meningitis in children as part of its service to its locality.

Treatment of Purulent Meningitis

Banice Feinberg, M.D., Visiting Pediatrician, Pawtucket Memorial, Rhode Island, Miriam, and Providence Lying-In hospitals; Consultant, Department of Pediatrics, Charles V. Chapin hospital.

To those of us who have been treating purulent meningitis before the era of chemotherapy and even as late as the end of World War II, nothing could be more gratifying or spectacular than witnessing a change from a 100% mortality rate in influenzal and tuberculous meningitis to a 95% recovery rate in the first instance, and a 50-75% recovery rate in the latter.

It is reasonable to expect recovery in the majority of cases of purulent meningitis, and it is hoped that all will recover. This happy circumstance can at least be approached by adhering to several important principles.

1. Making an accurate bacteriologic diagnosis as quickly as possible.
2. Selecting optimal drug or drugs with adequate dosage.
3. Early recognition, prevention, and treatment of complications which might lead to permanent cerebral complications.

The following outline in the treatment of purulent meningitis is based upon a review of the recent literature and the cumulative experiences at the Memorial Hospital, the Rhode Island Hospital, and the Charles V. Chapin Hospital in Providence.

Since success in treatment of meningitis concerns itself a great deal with antibiotics, it might be wise to list the principal ones with their commonly used trade names.

TABLE 1

Antibiotic Synonyms

Chloramphenicol	Chloromycetin
Chlortetracycline	Aureomycin
Oxytetracycline	Terramycin
Tetracycline	Achromycin (Lederle) Tetracin (Roerig) Polycycline (Bristol) Panmycin (Upjohn) Steclin (Squibb)

TABLE 2

Treatment of H. Influenza Meningitis

I. Chloromycetin or Tetracycline: 1st dose 50mgm. per lb. body wt. i.v. drip. Then 50mgm. per lb. per 24 hrs. i.m. divided doses until temperature is normal and tolerated orally. Continue 10 days.

II. Sulfadiazin: grains 1-2 per lb. per 24 hrs. in divided doses.

TABLE 3

Treatment of Meningococcic Meningitis

Sulfadiazin: grains 1-2 per lb. body wt. in 24 hrs. to produce blood level 10-15 mgm.%. 1st dose i.v. or subcu.—½ of 24 hr. dose, then regular dose (⅓) q. 8 hrs. until tolerated orally. Continue until temp. is normal 1 week.

Alternate Treatment. Procaine penicillin 1 million units twice daily i.m. for 1 week.

TABLE 4

Treatment of Waterhouse-Frederichsen Syndrome

Emergency—Treat intensively and quickly

I. Adrenal Cortical Extract—10cc. q. 4 hrs. i.v.

II. Cortisone—100mgm. per day i.v. 2-3 days.

III. Penicillin—Aqueous—1,000,000 units in i.v. drip q. 3 hrs., or i.m. q. 3 hrs.

or Sulfadiazin—grains 1-2 per lb. body wt. in i.v. as per table 3.

IV. Plasma and/or I.V. Dextrose

V. Oxygen

VI. Continuous Supervision. There are very few medical conditions that are more grave than this awesome syndrome. Many of these can recover by early recognition and the institution of immediate, expert and heroic measures. Continuous medical supervision for the first 12 hours is indicated. The picture of petechiae, shock, peripheral vascular collapse, coma, with other evidences of meningococcic infection, once seen, is not easily forgotten.

TABLE 5

Treatment of Pneumococcic Meningitis

I. Penicillin—Aqueous—1,000,000 units q. 2-3 hrs., i.m. or 10 million units in 24 hrs. via i.v. drip, until temp. is normal. Then procaine penicillin 600,000 units 2 times a day for 1 week.

II. Sulfadiazin—grains 1-2 per lb. per 24 hrs. to produce blood level 10-15mgm.%.

Treatment of Streptococcic Meningitis

Same as pneumococcic meningitis

TABLE 6

Treatment of Staphylococcic Meningitis

I. Penicillin—Aqueous—10-20,000 units intrathecally, well diluted in normal saline, once daily for 3 days PLUS 1,000,000 units i.m. q. 3 hrs., or 10,000,000 units per 24 hrs., via i.v. drip until temp. is normal. Then procaine penicillin 600,000 units 2 times daily for 1 week.

II. Sulfadiazin—grains 1-2 per lb. per 24 hrs. to produce blood level 10-15mgm.%.

or Erythromycin—10-20mgm. per lb. per 24 hrs. for penicillin resistant organisms.

TABLE 7

Treatment of Tuberculous Meningitis

I. Streptomycin—1.0 gram per day i.m. until CSF sugar has remained normal 2 weeks. Then 3 times a week for 6 mos. divided doses q. 12 hrs.

II. Isoniazid—1 yr.—5mgm. per lb. per day divided doses q. 12 hrs.—orally—(i.m. if necessary).

III. Promizole—1-2 yrs. 0.25-5.0 grams per day, orally, divided doses q. 6 hrs. Produce blood level 1-3mgm.%.

TABLE 8

Treatment of Undiagnosed Meningitis

Same as H. Influenza Meningitis.

Chloromycetin or Achromycin plus Sulfadiazin. Watch spinal fluid for return to normal of sugar and protein. If no improvement, change to PENICILLIN and STREPTOMYCIN PLUS SULFA.

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TABLE 9

Treatment — Purulent Meningitis — Summary

H. Influenza	CL. or TET + SD
Meningococcic	SD or PEN
Pneumococcic	PEN + SD
Streptococcic	PEN + SD
Staphylococcic	PEN or ER + SD
Tuberculous	STR. + ISO + PROM
Undiagnosed	CL or AC + SD or PEN + STR + SD

Legend: CL=Chloromycetin; TET=Tetracycline; SD=Sulfadiazin; PEN=Penicillin; STR=Streptomycin; ER=Erythromycin; PROM=Promizole; ISO=Isoniazid.

Despite adequate therapy, or due to less than optimal or delayed therapy, recovery has occasionally been interrupted by subdural collections of fluid. This fluid has a high protein, is xanthochromic and often resembles traumatic subdural hematomata. Most of these can be treated adequately and conservatively by removal of fluid by subdural taps; resorting to surgical burr holes and removal of membrane if repeated taps over a period of two to three weeks do not relieve the condition.

CONCLUSION

Broad spectrum antibiotics together with penicillin, streptomycin, sulfas, and isoniazid have completely revolutionized the treatment of meningitis. Intrathecal therapy is necessary only in rare instances. The greatly improved outlook provides one of the most gratifying chapters in medical history.

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LOOKING AHEAD IN MENTAL RETARDATION

RHODE ISLANDERS who are concerned about the special problems of mentally retarded children can share with pride in the nation-wide interest shown in the remarks of Rhode Island's Congressman Fogarty in the House of Representatives at our national capitol on March 21. As chairman for the fifth time of the House Committee responsible for the annual budget of the Department of Health, Education and Welfare and related agencies, he was instrumental in having included in the bill covering the appropriation for 1955-56 (H.R. 5046) a new item of $750,000 to initiate a program of research on mental retardation. In his remarks before the House Mr. Fogarty displayed an enlightened and clinically sound understanding of the need for such research, and of some of the main channels through which it may be profitably pursued.

While some may wish to debate the wisdom of appropriating Federal funds for medical research, there can be little quarrel with the need for improving our understanding of a handicap which involves some four and one-half million Americans and their families. Among the ultimate goals of knowledge derived from research in mental retardation are the eventual prevention of the handicap in many instances and the assurance of optimal happiness and productivity for those who are affected by improved facilities for their training and education. The days have passed when the medical profession and the community may complacently assume that most mental retardation is inevitable since it is passed from generation to generation on an hereditary basis. Present knowledge suggests that a notably small percentage of children are retarded primarily for genetic reasons.

Mr. Fogarty has indicated that his interest in the whole subject was initiated by an invitation he received to address the parents of retarded children in Rhode Island. His comment well indicates the potential stimulation regarding problems of retardation which can originate in the many similar parent groups which have banded themselves together in a variety of organizations from coast to coast—to a large extent during the last five years. Their influence, together with that of professional workers who have labored in semi-obscurity in the field for many years, is beginning to be reflected in many ways. This year the Rhode Island General Assembly passed, and the Governor signed, a bill appropriating $40,000 to reimburse cities and towns for one-half the cost of providing special facilities or transportation to existing special facilities for retarded children in day schools approved by the

continued on next page

State Board of Education. Due regard is given to children who can profit from various types of instruction. Other states and many larger cities are setting up experimental or permanent programs for retarded children in community schools, thus following a precedent set by such places as New York City, which has had special classes for many years.

Mr. Fogarty indicated his interest in having mentally retarded youngsters referred to as "exceptional children." This is a term which has been in common use, particularly in special private school circles, for a good many years. It represents a sincere attempt to remove from our terminology labels which convey the stigma traditionally attached to mental retardation in years past. Designations such as "idiot," "imbecile" and "moron" have recently been deleted from standard nomenclature for this very reason, and more neutral, descriptive terms indicating the degree of retardation have been substituted. It is unlikely that a new vocabulary alone can remove a heritage of derogatory thinking. However, non-discriminatory terms used in widespread, sympathetic discussion, plus enlightened planning and a realistic, objective approach to research with mentally retarded children, make the future for these youngsters and their families look immeasurably brighter.

THE POLIO VACCINE

The demonstration of effective artificial immunization against poliomyelitis marks a great achievement in the prevention of this disease. Dr. Thomas Francis, Jr., of the University of Michigan in his preliminary report on the mass inoculation trials of 1954, using the Salk polyvalent vaccine, has shown that apparent immunity was demonstrated in a range of from 60 to 90 per cent, depending on the type virus antibody tested. Effective immune response to type I (Brunhilde) virus varied from 60 to 70 per cent and was not as marked as the response to type II (Lansing) and type III (Leon) viruses which showed an overall effective response of 90 per cent or more. Protection against paralytic poliomyelitis was estimated to be in the range of from 80 to 90 per cent.

Evaluation of the results in this country was based on the records of a total of 1,830,000 school children, six to eight years old, living in 217 selected areas in forty-four states. Of this number, approximately 440,000 children received three injections of vaccine and the remainder received either a placebo or served as observed controls.

The effectiveness of the vaccine in future trials promises to be even better, especially after the vaccine itself has been further improved to increase its potency. Much has been learned in this regard from the field trials of last year. For example, it was found that when merthiolate was used as a preservative in some of the vaccine lots, the potency of the vaccine was impaired; however, when merthiolate was used in conjunction with a sequestering compound like versene, the vaccine gave an excellent response. Had the merthiolate-versene vaccine preparation been used in all of the testing, one might expect even higher percentages of immunity than those obtained.

In the course of this study, it was found that the timing of vaccine injections greatly influences the degree of antibody stimulation. It was observed that the most effective time to give the vaccine is about four to five weeks after the first dose, and then not again until after seven to twelve months. Giving the third dose before seven months elapsed had little effect on increasing the serum titer; but when the third dose was given after seven months, the titer doubled in a short while and was equal to or greater than that produced by an actual infection with the poliomyelitis viruses. It was pointed out that primary vaccination, that is, two or three injections within five weeks, potentiates the antibody-forming system to produce large amounts of virus antibody in a short while on subsequent contact with poliomyelitis virus either by exposure to live virus or by booster injection, especially if this occurs seven to eight months later.

Most vaccines that have been perfected are effective in a range of only 90 per cent. This may not be entirely the fault of the vaccine, for it is known that a small percentage of individuals have poor antibody-forming apparatus to start with. The demonstration of active immunization against poliomyelitis up to 90 per cent is very encouraging in a disease such as this, for which there is no cure and no preventive treatment other than the use of gamma globulin which confers only a transient passive immunity. If protection is not complete in all vaccinated cases, the use of the vaccine may modify the degree of muscle paralysis and recovery may be more complete.

Another important finding from the trials is the demonstration of effective use of a killed virus vaccine so that there is no risk of infection. Formaldehyde was used to inactivate the virus. Effective immunization against some virus infections, smallpox for example, is possible only if a living vaccine preparation is used. In recent years certain viruses such as influenza, rabies, and equine encephalitis have been shown to give good antigenic response when completely inactivated by chemicals or ultra-

violet light, but in general an inactivated virus preparation does not evoke such firm immunity as does live material.

Whether or not a vaccine can be used will depend on the side reactions produced. In this study, only 0.04 per cent of the children receiving the vaccine showed reactions of any sort and these were minor. So-called major reactions were almost completely lacking; those few that did occur could not be attributed to inoculation.

Considerable optimism about the use and effectiveness of the poliomyelitis vaccine is warranted, but there are, of course, some questions that remain to be answered. This will be possible only after more mass inoculation trials have been completed and after more time has elapsed to further evaluate these studies. Perhaps most important is the question of persistence of adequate antibody levels to prevent paralytic poliomyelitis. Will booster injections be necessary, and if so how often will these be required? Side reactions were shown to be remarkably low in the 1954 trials, but these will undoubtedly increase when the results of future mass inoculation trials are added to the data and especially so if repeated booster injections are found to be necessary. While antibodies produced by the vaccine may be sufficient to prevent access of the virus to the CNS via the blood stream, still it may be possible for the virus to invade by way of the nerve pathways. Another factor that may complicate the picture in the future is the emergence of new immunologic strains among the three recognized types of poliomyelitis virus, or the discovery of more than the three virus types.

Many scientists have contributed to the demonstration of effective immunization against poliomyelitis. Foremost of these is Dr. John J. Enders and his associates of the Children's Medical Center in Boston who received the Nobel prize for demonstrating growth of the three virus types in tissue cultures of other than nervous origin, thereby allowing mass production of the virus as is required for large scale production of the vaccine. Dr. Dorothy Horstman of Yale and Dr. David Bodian of Johns Hopkins discovered circulating poliomyelitis virus in the blood stream which confirmed the existence of a viremia before invasion of the nervous system. This work suggested that antibody in the circulation could act on virus to remove it before the virus could produce injury in the CNS. Dr. Howard H. Howe and Isabel Morgan, also of Hopkins, did the initial work on chemical inactivation of live poliomyelitis virus. Dr. Jonas E. Salk and his associates at the University of Pittsburgh set up the first clinical trial of a killed vaccine in the first inoculation series of 1953. These results gave considerable promise of success. The results of the work of all of these scientists made the mass experiments of 1954 possible.

MISS FITZPATRICK

Among its foremost citizens, Rhode Islanders are proud to class a group of distinguished women, of whom no finer example could be selected than the late Winnifred L. Fitzpatrick. As administrative head of the Providence District Nursing Association in the days when that organization was first recognized as the national leader in this field of public service, Miss Fitzpatrick, by a rare combination of personality, ability and tireless diligence, made the work of her group a model. Nurses came for training under her supervision from all parts of the country and from abroad. She, as practical administrator, and Miss Mary Gardner as director, were an example of as perfect teamwork as is possible for human beings.

To those who knew "Winnie," as her older friends loved to call her, her kindness and humility made her especially dear. How often on her way home from a busy day at her office she would stop to give a sick neighbor or friend some welcome nursing attention, only her intimate acquaintances knew. Her kindness and compassion, and her deep understanding of people made her life in the tradition of Florence Nightingale a model for all of us in the professions of nursing and of medicine. In her passing, the people and the medical profession of Providence have lost a beloved friend.

HENRY MERRITT WRISTON

The retirement of President Wriston from Brown at the end of the academic year is a matter of concern for all citizens of the state. It is not necessary to recount the achievements of this remarkable fellow citizen of ours, for this has been accomplished by the lay press in an able and understanding manner. It can hardly be that there are many doubters in this vicinity as to his abilities. He has made a wonderful record. He is the very model of a modern university president. How Brown has developed and matured under his dynamic leadership is known to us all.

One of the most valuable qualities which he possesses is his ability to tell us in his speeches something of what he has in his mind and which certainly we should retain in our minds. His wonderful speaking voice with his tremendous resonance and his elocutionary ability have made him easily one of our most valuable public speakers.

His work has been of deep interest to the medical profession, partly because the broad cultural base on which he has insisted as standard equipment for Brown men, as they have entered upon their careers, is, we believe, essential to those who enter the medical profession. Physicians, to merit the full confidence of their patients, must appeal to them, not only as expert technicians, but as understanding and broadly intelligent advisors.

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* * *

We would like now to think a bit of Dr. Wriston's successor and the manner of his choosing. By some quirk of mind, which perhaps you will understand, we are led to think of the story told us by Dr. Samuel Adelson of Newport.

A Jewish boy came to this country unable to read or write. The Jews, who always look out for their own, quickly got him a job as a janitor. He was such a good worker that he had the place well cleaned before the day was over. The employer, wishing to keep him busy, set him to sorting packets in the basement, but this required reading and he couldn't do it. He was fired. His friends then bought him a pushcart and he collected old rags and bottles. Not too long afterwards, he was shipping waste metals in shipload lots.

Needing money to expand, he went to the Chase National Bank and asked for a loan of a million dollars. The next day the bank president announced that they were prepared to lend it, made out the papers, and handed them to him for his signature, whereupon he made a cross and had to explain that he could not write. The president looked at him in astonishment and said, "My, my, you a multimillionaire and can't sign your name. What would you be if you only had an education?" The Jewish boy replied, "I would be a janitor." We wonder if he is on the Governing Boards of any universities.

The papers have the list of the committee who are choosing the new president. Like the list of the corporation, it consists, excepting one woman, of smart businessmen and their legal advisors. All the businessmen are presidents of great industrial organizations. Now we are great friends and admirers of practically all these men, but we often wonder if it is necessary to make quite such great transitions from the old customs when more of the Corporation of the University were chosen from the learned professions.

President Wriston in his speeches has stressed the importance of a broad cultural education rather than a mere training. Now we have known many cultured businessmen with the outlook on life that the broadest education would give them, but we can't help feeling that taking them as a whole, they are bound by the nature of their work to be possibly a little too far toward the material side. President Pusey in his recent talk before Brown University men called attention to the fact that centuries ago the church absolutely dominated education. In this country it was perhaps more dominated by the state.

Harvard had a very difficult time during the years when half of their governing board were representatives of the state. This was not changed until the period of the Civil War. Since then, the domination of industry has been strong, and he asks us, "It therefore raises the very serious question: Which is to exert the guiding pressure? . . . The present greatest threat comes from forces largely economic that almost engulf our daily life." In view of the fact that President Pusey is a young man who we understand was largely brought up by President Wriston, I think we may say right here "The voice is Jacob's voice, but the hands are the hands of Esau." All this does not sound like a plea to have Henry Wriston's successor chosen by big businessmen alone.

Of course, what is really making us doctors feel like going out in the garden and eating worms is the fact that at Brown University we medical men have for nearly a century not been considered to have qualifications valuable for educational affairs. Dr. Pusey's University does not feel that way. Our friend, Dr. Roger Lee, has just ended a quarter century at the top of the Corporation of Harvard University, which to paraphrase the remark of the Model T driver to the Cadillac owner, is a good university too. If anybody can rise higher than that in the educational field, point him out to us.

Well over a century ago, Brown had one of the most promising medical schools in the United States. President Wayland, himself educated as a physician, for some reason, not well understood as far as we know, brutally slayed it. In this second largest city in New England, the largest center of population in the United States still without a medical school, we might well have had a valuable medical school now.

Many men interested in medical education are not at all satisfied with premedical education. They think that the medical schools are getting a group of boys who have plugged hard at training in order to get good marks in technical subjects which will slip them into medical school. What we would like to see are some broadly educated young men whose minds have been developed for something besides memorizing the routine work of a physician.

PHYSICIANS SERVICE ELECTIONS

At a meeting of the board of directors of the Rhode Island Medical Society Physicians Service, held in March, Dr. Charles J. Ashworth, treasurer of the corporation for more than five years, was elected president to fill the vacancy caused by the death of Doctor Joseph C. O'Connell. Doctor Orland F. Smith, a member of the board of directors since the inception of the program, was named as treasurer to succeed Doctor Ashworth in that office.

Elected to fill the vacancy on the board of directors, to serve until the next meeting of the Corporation in January, 1956, was Doctor G. Edward Crane.

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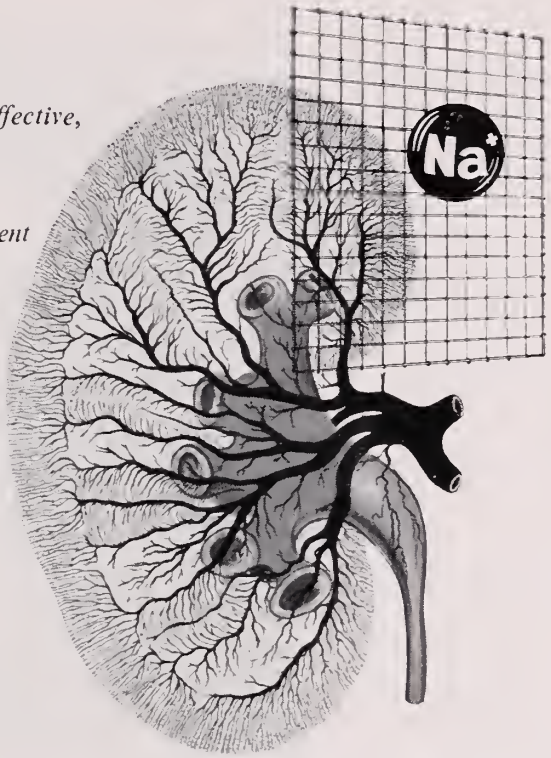
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Increased sodium ion excretion following administration of Mictine indicates the inhibition, or "screening," of reabsorption of this ion, as well as increased elimination of water and chloride.

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Clinical Field—Mictine is useful primarily in the maintenance of an edema-free state and in the initial and continuing control of patients with mild congestive failure. Mictine may be used also for initial and continuing diuresis in more severe congestive states, particularly when mercurial diuretics are contraindicated.

Administration—The usual dosage for the average patient is one to four tablets daily in divided doses with meals and on an interrupted schedule. The latter may be accomplished by giving the drug on alternate days or for three consecutive days and then omitting it for four days.

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Supplied—Uncoated tablets of 200 mg.

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FRANK B. CUTTS, M.D.
of Providence, R. I.
President of the Rhode Island Medical Society
1955 — 1956

PRESIDENT'S MESSAGE

LINCOLN ONCE SAID, "The legitimate object of government is to do for a community of people whatever they need to have done, but cannot do at all, or cannot do so well, for themselves, in their separate and individual capacities." This same relationship, I believe, exists between our medical society and its individual members.

Moreover, since stimulation of the pocketbook is known to arouse the subject's interest, and since your annual dues of $50.00 can be considered adequate stimulation, you should be interested in some of the benefits of membership in the Rhode Island Medical Society. A brief and incomplete list includes the following:

1). Scientific meetings which afford us an opportunity to hear talented and authoritative speakers on various aspects of medicine.

2). The privilege of becoming acquainted with doctors from other hospitals and communities within the state and thus acquiring some knowledge of their problems and points of view. Service on one of our various committees or in the House of Delegates greatly increases this opportunity.

3). The use of a good medical library.

4). A medical journal which provides us with scientific reports and disseminates information of general and local interest.

5). Finally, and most important in these changing times, is the work of our committees and representatives continually guarding our interests and the health welfare of the community. To mention only a very few, consider our majority representation on the board of the Rhode Island Physicians Service, our spokesmen on the board of Blue Cross, our active legislative committee with its multitudinous annual problems, our committee on Medical Defense and Grievance, our committee on Social Welfare, and our Committee on Public Policy and Relations. Implementing the activities of these groups and amplifying their effectiveness is our efficient Executive Secretary, John E. Farrell.

I believe the evidence indicates that we receive excellent value for our dues. However, this does not imply that we as a Society are doing all we should, or that present performance leaves no room for improvement. Your officers welcome constructive criticism. We do not promise to adopt all your suggestions but we do guarantee them careful consideration. A good medical society, like a good man, is constantly becoming better.

FRANK B. CUTTS, M.D., *President*



JOHN G. WALSH, M.D.
of Providence
Vice President of the Rhode Island Medical Society, 1955-1956



CHARLES L. FARRELL, M.D.
of Pawtucket, R. I.
President-Elect of the Rhode Island Medical Society, 1955-1956

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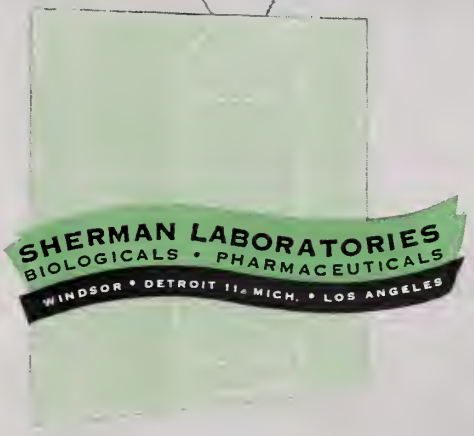
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*Smith, R. T., New York Med. 8:16, 1952.



DISTRICT MEDICAL SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

A regular business meeting of the Pawtucket Medical Association was held December 16, 1954, in the library of the Pawtucket Memorial Hospital with ten members present.

The minutes of the November meeting were read and approved.

Several communications were read:

1. from John E. Farrell of the Rhode Island Medical Society indicating that it is the intention of the State Society to eliminate the results of our poll on social security for doctors from their next publication,

2. from Harold Bradbury, secretary of the Spatula Club, thanking the Pawtucket Medical Association for the recent dinner and meeting with the druggists,

3. from the Association of American Physicians and Surgeons, thanking us for our donation of $25.00 to their "Freedom Program."



FRANCIS E. HANLEY, M.D.
President, 1955
The Pawtucket Medical Association

The application of Doctor Edmund Billings for associate membership was referred to the Standing Committee.

Doctor Thomas J. Mathieu was elected to Associate membership by unanimous vote.

The application of Doctor Marian Zawirski was tabled for one year.

Regarding social security for doctors, after considerable discussion it was moved that "the secretaries of the various district societies be advised by letter as to the result of our recent poll on social security for doctors." Seconded by Doctor Charles L. Farrell and carried on a voice vote.

Doctor James P. Healy moved "that our delegates be instructed to notify the House of Delegates concerning the poll and the results." Seconded by Doctor Charles L. Farrell and carried on a voice vote.

The meeting adjourned at 12:30 P.M.

* * *

The Christmas Party was held at the Lindsey Tavern on the night of December 16, 1954. Forty-eight members were present, enjoyed a good dinner, exchanged gifts and sang the usual Christmas songs. A good time was had by all.

* * *

The regular business meeting of the Pawtucket Medical Association was held at the Lindsey Tavern on January 20, 1955, with twenty-seven members present.

The minutes of the December meeting were read and accepted.

The letters recently sent to the secretaries of the district societies and to our delegates regarding our poll on social security for doctors were read. It was indicated in these letters that the results of the poll might not be published in the RHODE ISLAND MEDICAL JOURNAL.

A letter from Doctor James G. Chapman thanking us for our recent felicitation was read.

The application of Doctor Joseph E. Seabra was read and referred to the Standing Committee.

Doctor Edmund Billings was elected to associate membership on unanimous written ballot.

Mr. Martin Kaufman discussed in detail the problem of income taxes. In effect he said that doctors would do much better, tax wise, if they had

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CIBA *Summit, N. J.*

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As you know . . . there's plenty of truth in that statement. It was made to the New York Stock Exchange in a recent survey of doctors who own stocks.

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"I believe that putting money into a savings account or insurance is not a sound way of building a reserve; it's too slow."

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PAWTUCKET MEDICAL ASSOCIATION

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their returns prepared by a tax expert or public accountant.

Doctor Harold Woodcome appointed a Nominating Committee for the year 1955.

Dr. James P. Healey, *Chairman*
Dr. Hrad H. Zolmian
Dr. Albert Giorgio

The meeting adjourned at 10:20 P.M.

* * *

A regular business meeting of the Pawtucket Medical Association was held February 24, 1955, at the Lindsey Tavern. Twenty-five members were present.

Dr. H. Zolmian presented the following slate of officers proposed by the Nominating Committee for the coming year:

President: Dr. Frank Hanley
Vice-President: Dr. Edward Foster
Secretary: Dr. John Hogan
Treasurer: Dr. David Ruggles
Councillor: Dr. Earl Mara
Delegates: Dr. Harold Woodcome, Dr. Robert Hayes, Dr. Hrad Zolmian, Dr. Henry Turner and Dr. James Chapman.
Standing Committee: Dr. James Healey, Dr. Kieran Hennessey, Dr. Laurence A. Senseman, Dr. Hrad Zolmian and Dr. Harold Woodcome.

Dr. Paparo suggested that a local chapter be formed as an adjunct to the Rhode Island Cancer Education Society. After some discussion the proposal was tabled without action for the time being.

Meeting adjourned at 10:00 P.M.

P. J. LAPPIN, M.D., *Secretary*

NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was called to order at the Hotel Viking on January 26, 1955, by Doctor Robert Bestoso, president, at 8:30 P.M., with twenty members attending.

The speaker of the evening was Doctor Richard Sexton, of the Rhode Island Hospital Staff, who spoke on "Lacerations of the Face and Hand." He mentioned the taking care of these lacerations during the first twelve to eighteen hours, how antibiotics have extended the time of care, and how local anesthesia under procaine with adrenalin was preferable in children especially. He also mentioned that extensive lacerations should be done under general anesthesia with endotracheal intubation.

He insisted upon the fact that one side of the face should *always* be compared with the other for aesthetic evaluation of the face with the necessary symmetry that should always be considered.

continued on page 284

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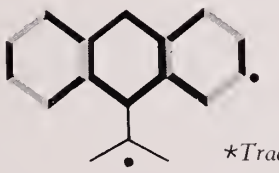
[*Wallis, R.: New York State J. Med.* 55:243 (Jan. 15) 1955.]

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NEWPORT COUNTY MEDICAL SOCIETY

continued from page 282

He then spoke at length on the treatment of nasal and malar fractures with their attendant complications, the method of suturing after debridement to avoid disfiguring scars and the importance of pressure bandages in these cases.

An interesting survey then was given by Doctor Sexton on lacerations of the ear, mouth, and hand, with emphasis on cheloid formation and tattoos.

The minutes of the last meeting of December first were read and approved by the members of the society.

COMMUNICATIONS: Dr. Ciarla made a motion that the application of Dr. Veit be tabled until she becomes a *practicing* member in the county. Dr. Malone then made a suggestion that the Secretary of the Society communicate with Dr. Veit in this regard. This motion was seconded by Dr. Adelson and passed.

A communication of the Pawtucket Medical Society dated December twenty-second was read before the members of the society. Dr. Adelson took the floor to explain that this communication did not explain whether or not the polls on the question of social security for doctors were voluntary or compulsory. He also insisted that all minutes of the district medical society meetings be published and submitted *in toto* with no omissions or expurgations.

Doctor Ciarla then made a motion that a letter be sent to the State Society recommending that there be no censoring of minutes of any county medical society, but that these minutes be published as stated in their entirety.

Doctor Dotterer then made the amendment that this motion be tabled until such time as the polls had been completed. This was passed unanimously by the members of the society.

The emergency orders of the Newport Public Health Nursing Association were read and approved by the members of the Society.

APPOINTMENT OF OFFICERS: A motion was made and seconded that the entire slate of officers of the Newport County Medical Society be reappointed. This motion was passed unanimously. The following officers were re-elected:

President—Robert L. Bestoso, M.D.
First Vice President—John M. Malone, M.D.
Second Vice President—Edward Zamil, M.D.
Secretary—José M. Ramos, M.D.
Treasurer—Donald B. Fletcher, M.D.
Councillor—Samuel Adelson, M.D.
Alternate Councillor—Charles B. Ceppi, M.D.
Delegates—John E. Carey, M.D.
Henry W. Brownell, M.D.
Censors—Norman M. MacLeod, M.D.
D. A. Smith, M.D.

Dr. Frank Logler, thereupon, advised all members of the Society to review their malpractice insurances and suggested that a minimum of $50,000 be considered for one policy and $150,000 for those who contemplated taking three policies.

The meeting was adjourned at 9:50 P.M.

Respectfully submitted,
José M. Ramos, M.D., *Secretary*

WOONSOCKET DISTRICT MEDICAL SOCIETY

A Woonsocket District Medical Society meeting was held on Tuesday, March 15, 1955, at the Woonsocket Hospital library. The meeting was called to order at 8:45 P.M., by Doctor Saul Wittes, president. Twenty-five members were present.

Minutes of the last meeting were read by Doctor Alton P. Thomas, secretary, and accepted with no omissions or corrections.

A letter received December 22, 1954, from the Pawtucket Medical Society was read. In essence, the letter stated that 68% of their membership had voiced their opinion on social security for doctors, and 46% were in favor of, and 21% were against this form of government protection. Doctor Francis Vose stated that this matter is under discussion now by the Rhode Island Medical Society and more information will be forthcoming. No action taken.

A letter received January 4, 1955, from the Woonsocket Public Health Nursing Association was read. It thanked the Woonsocket Medical Society for its cooperation in the chest survey clinics of last fall in which 13,901 chest X rays were taken in this community—a new record.

A letter received February 15, 1955, from the Rhode Island Department of Health, Northern District, was read. It requested the approval and cooperation of the Woonsocket District Medical Society in the program of immunization against infantile paralysis tentatively set to be carried out in April of this year. It is planned that all children of the first and second grades in school, public and private, will receive a series of three injections, upon request of their parents or guardians. Doctor Philip Morrisson made a motion, seconded by Doctor Auray Fontaine, that the Woonsocket District Medical Society would actively support any program of polio immunizations in this area. Passed unanimously.

There being no other business before the society, the business portion of the meeting was adjourned at 9:00 P.M. and Doctor Henri Gauthier, president of the Rhode Island Medical Society, introduced the speaker for the evening.

The speaker was Doctor George V. Smith, chief

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1. Riseman, J. E. F. and Brown, M. G. Arch. Int. Med. 60: 100, 1937.
2. Brown, M. G. and Riseman, J. E. F. JAMA 109: 256, 1937.
3. Riseman, J. E. F. N. E. J. Med. 229: 670, 1943.

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WOONSOCKET MEDICAL SOCIETY

continued from page 284

of gynecology at the Free Hospital for Women, Brookline, Mass., and professor of gynecology at the Harvard Medical School. He gave a complete and stimulating résumé on the usage of the female sex hormones. The lecture was followed by a question period of about one-half hour during which controversial issues were brought up, and some lively discussions ensued. Doctor George V. Smith was assisted in the question period by his wife, also an expert on female endocrinology.

Meeting adjourned at 10:45 P.M. and refreshments were served in the hospital cafeteria.

Respectfully submitted,

ALTON P. THOMAS, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

The regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, March 7, 1955. The meeting was called to order by the President, Francis H. Chafee, M.D., at 8:40 P.M.

Minutes of Previous Meeting

The minutes of the previous meeting of the association were submitted and the president announced that the minutes would be published in the RHODE ISLAND MEDICAL JOURNAL.

Communications

The secretary reported a communication from the Community Workshops of Rhode Island inviting physicians to attend the twenty-fifth anniversary luncheon-meeting on March 23, 1955, at which Doctor Dean Clark of the Massachusetts General Hospital would be the speaker.

The secretary read a communication from the American Medical Association announcing the sponsoring by the United States Junior Chamber of Commerce, in cooperation with the National Health Council, of "Community Health Week" to be celebrated throughout the country March 21, 1955 to March 27, 1955.

Report of Executive Committee

Doctor Michael DiMaio, secretary, reported that the executive committee recommended for election to active membership to the association the following physicians: Paul A. Holzinger, M.D., 670 Chalkstone Avenue, Providence; Olga Koropej, M.D., State Hospital for Mental Diseases; Harvey Phillips Lesselbaum, M.D., Miriam Hospital, Providence; Daniel Shao-Fu Liang, M.D., 155 Angell Street, Providence; Charles Elliott Magraw, Jr., M.D., 305 Blackstone Blvd., Providence; and Raymond Edward Moffitt, M.D., 187 Waterman Street, Providence.

Award of Membership Certificates

The president issued certificates for active membership to the physicians who were elected at the February meeting of the association: Demitru Caramiciu, M.D., and Leo Richard Licis, M.D.

Announcements by the President

The president announced the appointment of the following committees to prepare obituaries to deceased members of the Association:

To prepare the tribute to the late Doctor Constant Schradieck, Doctors James H. Prior and Jack Savan.

To prepare the tribute to the late Doctor Frank Jacobson, Doctors Stanley Freedman and Harold G. Calder.

To prepare the tribute to the late Joseph C. O'Connell, M.D., Doctors John G. Walsh and John E. Donley.

Report on Chamber of Commerce

The president introduced Mr. Thomas Gilbane, president of the Providence Chamber of Commerce, who spoke briefly on the work of that organization and urged that physicians accept membership and participate in activities in the various programs for the development of Greater Providence.

Medical Exhibitor

The president introduced Mr. Walter Kiley, New England representative of the Dietene Company of Minneapolis. Mr. Kiley spoke briefly on the display of his company presented at the meeting.

Address by Dr. Frank G. Dickinson

The president introduced Doctor Frank G. Dickinson of Chicago, Illinois, director of the Bureau of Medical Economic Research of the American Medical Association, to discuss "The Retirement Problem of Physicians."

Doctor Dickinson reviewed the Federal Old Age and Survivors System. He discussed in detail how physicians would be covered under it and pointed out the possible advantages and disadvantages of physicians participating in it. He called to the attention of the members his article on "Reappraisal of Social Security" published in the AMERICAN MEDICAL ASSOCIATION JOURNAL.

The meeting adjourned at 10:10 P.M.

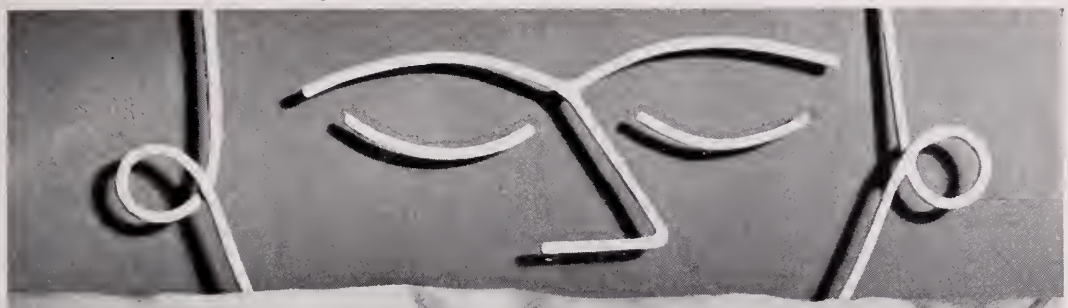
Attendance was only 47 as a result of a snowstorm which occurred three hours before the meeting was called to order.

Collation was served.

Respectively submitted,

MICHAEL DIMAIO, M.D., *Secretary*

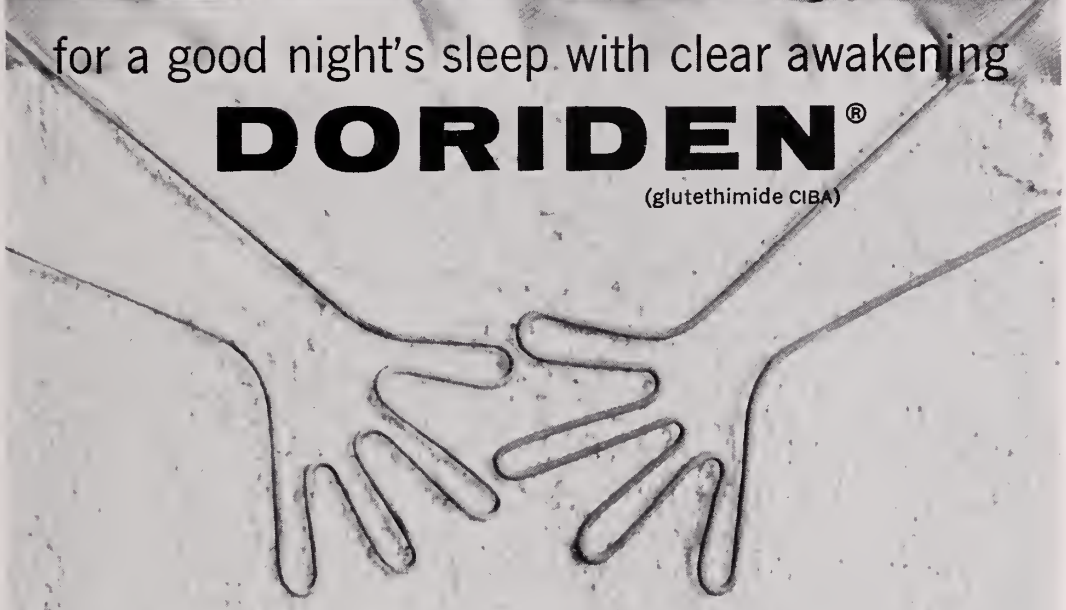
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THE WASHINGTON SCENE

A Legislative Review after three months of the 84th Congress prepared by the Washington Office of the American Medical Association

The following report, prepared by the Washington Office of the American Medical Association, brings the federal legislative picture of the first three months of the year into focus. It deals with trends that have developed, as well as official actions, and the AMA's policy and the reasons for it are given in relation to general subjects as well as to specific bills. Brief study of this report should give you a clearer understanding of what has happened in Washington the past three months, and what may be expected when Congress plunges into its most active period.

THE EDITOR

Reinsurance

What Bills Would Do: This legislation provides an initial $25 million to start a trust fund that would be maintained by percentage payments from premiums of participating health insurance plans. The total U.S. contribution would be $100 million. The fund would reimburse voluntary health insurance plans (commercial and nonprofit) for abnormal losses in extending coverage and expanding benefits. Cited by the Administration bill as areas where reinsurance would be helpful are catastrophic illness and coverage of rural families and low-income groups. Participation would be voluntary on the part of insurance companies.

Status of Bills: Chairman Priest of the House Interstate and Foreign Commerce Committee has said hearings will be held on this subject, but no date has been set. Chairman Hill of the Senate Labor and Welfare Committee has not indicated an interest in the bill nor is there strong support apparent among members generally. The Administration, principally through the President and Mrs. Hobby, has made plain that it will press hard for reinsurance, which has been identified as at the top of the White House "must list" for health legislation. The bill is little changed from last year's measure which was defeated in the House. Bills before this Congress: Title I of the following Administration omnibus health bills: S. 886 (Smith of N.J. and 8 others), H.R. 3458 (Priest) and H.R. 3720 (Wolverton), also H.R. 400, 401, and 2533 (all by Wolverton).

AMA Policy: While indorsing the stated purposes of the bills (to promote the best possible medical care on reasonable terms), the American Medical Association again opposes the proposal on the grounds that (1) extensive private funds are available within the insurance industry for such purposes, (2) reinsurance doesn't provide a means for making insurable what otherwise would be an uninsurable risk, (3) it will not fulfill its intended purpose and might even inhibit the satisfactory progress made to date by voluntary plans, and (4) it is a potential subsidy.

Mortgage Guarantee for Health Facilities

What the Bills Would Do: For a fee, would guarantee up to 95% of private mortgages for construction of non-government health facilities, to be owned and operated for profit or on non-profit basis. The mortgage could not exceed 80% of the estimated value of the project and equipment, and maturity could not exceed 30 years. The guarantee would apply to refinancing, as well as to new construction and modernization.

Status of Bills: Now the Administration is behind this legislation, although it did not support the measure pressed by Rep. Wolverton in the last Congress. The new bill eliminates the requirement that 60% of the insured facility be reserved for group practice, prepayment plans. Last year's bill had the strong support of Industrialist Henry J. Kaiser, who founded a West Coast network of hospitals and clinics that would qualify for the benefits. Secretary Hobby has designated this as one of the two most important Administration health measures, the other being reinsurance. Last year labor witnesses also were in favor of mortgage guarantees. Hearings have not been scheduled as yet, but it is assumed they will be. Bills: Title II of S. 886, H.R. 3458 and H.R. 3720; also H.R. 397 and H.R. 398 (both Wolverton).

The AMA Policy: The Association is actively opposed to this legislation on grounds that (a) private financing is meeting the need, and (b) the proposal represents intrusion by the federal government into a field where government help is not required.

Mental Health

What the Bills Would Do: The Administration wants a new five-year program of increased grants

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(1) Payne, R. W.; Shetlar, M. R.; Farr, C. H.; Hellbaum, A. A., and Ishmael, W. K.: J. Lab. & Clin. Med. *45*:331, 1955. (2) Bunim, J. J.; Williams, R. R., and Black, R. L.: J. Chron. Dis. *1*:168, 1955. (3) Holbrook, W. P.: M. Clin. North America *39*:405, 1955.

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THE WASHINGTON SCENE

continued from page 288

to states on a need-population-per-capita-income formula to help maintain and improve mental health services, to stimulate special projects, and to train more personnel. Chairman Priest in the House and Chairman Hill and 29 others in the Senate are proposing federal grants to non-government professional groups and associations to finance an intensive three-year, $1,250,000 survey of mental health problems. Senator Purtell has still another plan, a permanent federal commission on mental health, which would study the problem, make recommendations and attempt to coordinate all work in this field, private as well as government.

Status of Bills: The survey bill has been reported to the House by Mr. Priest's Committee and hearings have been completed in Senator Hill's Committee, with every expectation that the bill will be sent to the Senate floor also. This is the first major health bill to make such progress this session. The Purtell bill for a government commission apparently will not get out of committee. The House committee has delayed consideration of the Administration's bill preferring to take it up later in connection with legislation for overhauling the entire public health grants setup. Bills: Title VI of S. 886, H.R. 3458, and H.R. 3720, and H.J. Res. 256 (Priest) and S.J. Res. 46 (Hill and others) and S. 724 and S. 848 (both Purtell).

AMA's Policy: The Association is wholeheartedly supporting the survey bill, and also favors the Administration bill, but only as a temporary measure until Congress has been able to redefine the federal and local areas of responsibility in public health matters. This interest in mental health problems dates back to the founding of the AMA more than a century ago.

Federal Aid to Medical Education

What Bills Would Do: Plans for federal aid to medical education range from "one-shot" construction grants to outright operating aid for schools increasing enrollment. Most prominent in this Congress are identical bills by Senator Hill and Rep. Priest. They provide a 5-year, $250 million program of construction, expansion, modernization, and maintenance grants to new and existing schools. New schools could get up to two-thirds of construction costs, while existing schools could receive the same percentage if they increase freshmen enrollment by 5%. Bills would allow up to 20% of a new construction grant to go into a school's permanent endowment for maintenance of the new facility. Another House bill in which there is interest is that proposed by Rep. M. G. Burnside (D., W.Va.). It calls for a five-year $300 million program, with one-half earmarked for new medical schools and the remainder for improvements in medical, dental, and other schools in the health fields.

Status of Bills: Senator Hill and Mr. Priest head the two most important committees on health matters. It is to be expected that they will arrange hearings on their bills, possibly very shortly. The Burnside bill and others could be considered at the same time. How much progress the bills will make in Senate and House will depend on a number of factors, including overall budget restrictions and workloads of both chambers. The Administration is not sponsoring an aid to medical education this year, but might not oppose the idea. There is considerable bipartisan interest in helping medical schools in some way. Bills: S. 1323 (Hill and 12 others), H.R. 4743 (Priest), H.R. 3297 (Burnside), H.R. 3543 (Anfuso), H.R. 4667 (Fogarty).

AMA Policy: The Association favors one-time construction, renovating and equipment grants to medical schools on a matching basis similar to the Hill-Burton formula, but opposes federal grants for instruction or continuing grants for operation or maintenance. It approves the Hill-Priest bill, providing some specific changes are made in line with the above policy. It opposes the Burnside bill, until he accepts changes that have been suggested to him.

Doctor Draft Extension and Military Medical Scholarships

What Bills Would Do: The Doctor Draft extension bill would continue the present act for another two years beyond its July 1, 1955, expiration date. Under the scholarship bill the government would pay up to $133 per month, plus tuition and fees. Students would be obligated for three years' active duty if the scholarship was for a year or less, and four years if for more than one year. The Defense Department is proposing this plan as part of its long-range program for procuring career medical officers; an extension of the Doctor Draft is its answer to the short-range problem.

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Status of Bills: The Doctor Draft issue is almost certain to come up for Congressional action, because of the imminent expiration of the act that for four and one-half years has supplied the military with physicians. Hearings have not yet been scheduled, however. It is planned to bring up scholarship bills ahead of draft extension. The three services have been supporting an extension for the last year, and eventually the Defense Department accepted this policy, making the present bill an official Administration measure. Doctor Draft bill is H.R. 2886 (Vinson); scholarship bills, H.R. 67 and H.R. 4645 (Bennett, Fla.) and S. 1444 (Russell and Saltonstall).

The AMA Policy: When there was a proven need for it at the start of the Korean War in 1950, the Doctor Draft was supported by the AMA. The AMA also supported one extension of the law. Now, in the face of the Defense Department's request for another (and peacetime) extension, the AMA's policy is unchanged. If it can be demonstrated that there is a continuing need for the act, the AMA will support the extension. Evidence so far presented has not established the need. The Defense Department admits the regular draft obligation will supply it with the young physicians it needs, but says that the Doctor Draft is required to bring in more experienced men with special skills and administrative ability. Without these, the Department insists, the military medical services cannot be maintained during the next two years. The AMA believes the services could do a great deal more to build up their regular Medical Corps and to make more efficient use of the experienced men now in uniform. The AMA supports the scholarship idea, provided that (1) a student not be approached by the military until he is fully matriculated in the medical school, (2) no student so selected receive any preferential treatment, and (3) number of military scholarships in a school not exceed 5% of any year's class or the total enrollment.

Military Dependents

What Bills Would Do: For the present irregular program of medical care for military dependents, the legislation would substitute a plan that would (a) apply a uniform definition of dependents to all services, (b) make all dependents eligible for the same amount of treatment, and (c) offer relatively the same degree of care regardless of residence of the dependents. Uniformed physicians and military hospitals would take care of all dependent patients within limitation of resources. Only the remainder would be treated by private physicians and in private hospitals. The Secretary of Defense could set a token fee schedule to be charged dependents in military facilities. Those not cared for

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by the military medical departments would pay about 10% of the costs themselves, with the U.S. paying the remainder either directly to physicians and hospitals or through health insurance policies.

Status of Bills: No hearings have been held or are yet scheduled on these administration bills, but it is likely that some action will be taken. President Eisenhower is anxious to have Congress provide a better medical care program for military dependents, and the White House can be expected to exert its influence when the time comes. There is a strong feeling in Congress that the present confused system of dependent care should be straightened out. Bills: Two identical Administration bills, S. 934 (Senators Russell and Saltonstall) and H.R. 2685 (Vinson), also H.R. 3009 (Brooks).

AMA Policy: The Association has no argument with the military services on most provisions of the Defense Department bill, but is unalterably opposed to one part of it. Whereas the Administration thinks the military medical departments should care for all the dependents they can handle, the AMA feels that dependents, like other civilians, should be treated by private physicians and in private hospitals unless these private facilities are inadequate. In the latter case it would be the military's responsibility to care for dependents. The AMA Chicago headquarters staff now is working on a set of principles to be recommended as a guide in amending this bill into acceptable form.

Tax Deferments

What Bills Would Do: The Jenkins-Keogh-Ray type bills vary in provisions, but all are designed to give self-employed physicians and others the same tax deferment rights as corporation employees. The bills would allow them to put a limited amount of their income into restricted retirement plans, paying income tax on it when received as annuity payments. Bills similar to that introduced by Rep. Oliver Bolton would liberalize the amounts of medical expenses for tax deduction purposes.

Status of Bills: The Treasury Department has studied some of the proposals, but the Administration is not supporting any, nor is there evidence that Congress plans to act on any of them this session. Annuity bills include H.R. 9 (Jenkins), H.R. 10 (Keogh), H.R. 2092 (Ray) and eight other bills. Medical expense deduction bills: H.R. 402 (Wolverton), H.R. 3492 (Williams), H.R. 3893 (Curtis) and H.R. 3911 (Bolton).

AMA Policy: The Association supports all these bills, but among the tax deferment proposals it prefers the Jenkins-Keogh approach.

Resolutions on Treaty Power

What Bills Would Do: Initiate constitutional amendments that would, in various ways, limit the power of the Executive Department to make treaties and executive agreements affecting internal matters.

Status of Bills: Although last year's Bricker resolution just missed getting the required two-thirds vote in the Senate, Congressional leaders have indicated they do not plan to take up the issue this session. Bills: S.J. Res. 1 (Bricker), H.R. 406 (Burdick), H.J. Res. 33 (Dondero), H.J. Res. 41 (Gross), H.J. Res. 60 (McDonough), H.J. Res. 103 (Bow), H.J. Res. 96 (Fisher), H.J. Res. 111 (Pelly), H.J. Res. 172 (Smith, Wis.).

AMA Policy: The Association favors these safeguarding resolutions in principle, because under present law it would be possible to impose medical licensure laws, or a program such as compulsory health insurance, through treaty alone, without requiring its passage by Congress as domestic law.

Grant Programs

Medical Care of Indigents: The Administration bill would authorize $20 million more in U.S. grants annually, to be earmarked for the medical care of the four classes of indigents for whose support the U.S. now contributes. The division would be $3 per month for each adult and $1.50 for each child, all of which would have to be matched by the states. It is an elaboration of the present program, under which the U.S. allows about $80 million per year for medical care of these indigents but does not require that it be used for this purpose.

In the same area, another Administration bill would revise the matching formulas for U.S. programs in maternal and child health and crippled children's services.

Pending further study of these bills, the Association has taken no position on them. Bills: H.R. 3293 (Reed) and S. 1198 (Cotton), also H.R. 3292 (Reed).

Other Grants Proposals: The Administration again wants to eliminate categorical grants to states for public health work, and substitute three broad groups: (a) general grants, (b) extension and improvement grants, and (c) special project grants.

The AMA supports the principle of eliminating categories, and will support the bill, provided (a) and (b) are combined and (c) is eliminated.

The Administration is proposing federal grants to states to help in combatting water and air pollution. The AMA favors bills for a study as well as state grants for air pollution. Bills: Title V of S. 886, H.R. 3458 and H.R. 3720 for grants; S. 849, H.R. 3459 and H.R. 4114 for laboratory facilities; S. 890 (ident.) and H.R. 3426, Water Pollution Control; S. 928, H.R. 835, H.R. 2129, and H.R. 3680 all air pollution.

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BOOK REVIEWS

A MANUAL OF TROPICAL MEDICINE by Thomas T. Mackie, M.D., George W. Hunter III, Ph.D., and C. Brooke Worth, M.D. 2nd ed. W. B. Saunders Co., Phil., 1954. $12.00

The first edition of this excellent manual (unique in its field) was published toward the end of World War II, primarily to meet the needs of the Armed Forces in the tropics. Ten years have elapsed before the appearance of this long awaited revision. In this new edition, the authors are to be especially commended for their skillful choice in the introduction of a number of disease topics found through their experience to be prevalent in the tropics and sanitarily backward areas. This includes trachoma, rickettsialpox, toxoplasmosis, gnathostomiasis, trichostrongyliasis; an enlarged chapter on virus encephalitides and nutritional diseases; a new chapter on medically important mollusks; as well as epidemic hemorrhagic fever which made its first notable appearance in the Korean War. Twenty-four authorities collaborated in part in the revision of this text, making it all the more authoritative.

Although tropical medicine has aways been taught and practiced hand in hand with hygiene, there is no existing text that combines the two. In this manual adequate stress has been laid on epidemiology and prevention, nevertheless, I would like to see a separate chapter on sanitation, particularly military sanitation. Perhaps this would offer some food for thought between now and the next edition.

S. K. Kaan, M.D.

STANDARD VALUES IN NUTRITION AND METABOLISM. Edited by Errett C. Albritton. W. B. Saunders Co., Philadelphia, 1954. $6.50

This monograph is the second in a series of fascicles, dealing with standard values of biological data. Quantitative data, contributed by more than 800 specialists in the field, have been condensed into 160 tables. The best single representative normal value for each item is given followed by the upper and lower limits of the 95 per cent range of values normally encountered. Items in tables are identified by coordinates; separate tables in the bibliography list complete references for the data presented. The format follows that of the first monograph Standard Values in Blood published in 1952. The book is comprehensive, easy to use and adequately indexed. It is paper bound, size 8½ by 11 inches, 380 pages.

The major divisions include: the essential nutrients and their sources; nutrients utilized by animal and plant forms; daily nutrient allowances for man and domestic animals; diets and culture media; energy values of foodstuffs; signs of deficiencies; pathways of metabolism; end products of metabolism; oxygen consumption and carbon dioxide production in both animal and plant tissues and organisms; and energy exchange.

This book should be of special assistance to those engaged in animal husbandry or agriculture; the practicing physician will probably find it of little immediate or practical value.

Wendell T. Caraway, Ph.D.

SMOKING AND CANCER: A Doctor's Report by Alton Ochsner, M.D. Julian Messner, Inc., 1954. $2.00

The crusader spirit reaches its acme of fervor in relation to tobacco and alcohol. The world must be saved from itself and these two noxious agents. Like the zealous temperance workers of yesteryear, in relation to alcohol; the ardor of the non-smokers (p. 59, "I myself have never smoked") is wonderful to behold.

One cannot quarrel with the facts and figures presented by Doctor Ochsner, but I believe one can quarrel with the facts and figures *as* presented. Statistics show without question that cancer of the lung *is* increasing. It is also a fact that most patients with cancer of the lung *do* give a history of cigarette smoking. However, I don't think that justifies the sensationalism which characterized the book. Carrie Nation was a sincere person, but many people deplored her methods.

p. 1 "Tobacco is a loaded, often lethal, weapon." "Lung cancer is in flood, and the flood is rising."

p. 2 "You may go blind from nicotine amblyopia."

"There are even indications that if you are a man you may become impotent, if a woman, sterile."

p. 30 "Incessant smokers, for the most part, can choose the site of their cancers."

These are but a few of the many examples of hyperbole which the book contains.

Even the charts are cleverly drawn to exaggerate the point to be made. Sometimes percentages, sometimes whole numbers; at one time rates per 100,000, at others rates per 1,000; and occasionally estimates presented in the same graph with fact; are old tricks used. Such tactics years ago gave origin to the common saying, "Statistics don't lie, but . . ."

Fear psychology and arguments based on fear have rarely promoted constructive thinking. If the facts are adequately established, why is it necessary to use the scare headline technique? "Methinks he doth protest too much." Facts, if they are actually facts, do not need embellishment.

The book is quite evidently a "quickie," designed to capitalize on the present timeliness of the recent publicity. It is poorly bound; the review copy is even now beginning to become unbound.

In short, I do not regard it as a worthy product of a scientist of Doctor Ochsner's unquestioned standing.

I have not stopped smoking yet. I may do so, but if and when I do, it will not be because of exposure to books like this.

PHILIP BATCHELDER, M.D.

POMP AND PESTILENCE by Ronald Hare, M.D. Professor of Bacteriology at London University. The Philosophical Library, Inc. New York, 1955. $5.75

This is an interesting and instructive book and easy to read. That does not mean, however, that it is pleasant reading.

Reading about disease, and especially infectious disease, is really not pleasing except it be produced by people with remedies for sale or popular so-called "science writers."

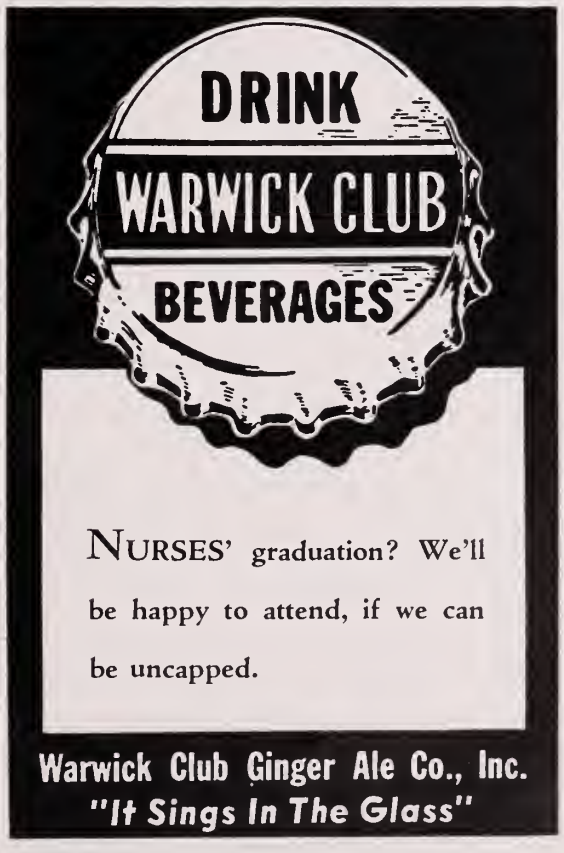
Hans Zinsser, in his RATS, LICE AND HISTORY, long ago showed us how disease had dominated the world which (we had been told by other historians) had been controlled by generals and politicians. But Doctor Hare by no means simply rehashes Doctor Zinsser. Man has lived a million years or so. There is evidence that he has had parasites for several times the length of the Christian era. Within the smaller part of a century he has learned much about these infections. We shelter and protect these parasites. It is not to their advantage to kill us off for they have to die themselves when this happens. But they are poor helpless things. Even when we do not die to spite them we frequently kill them. Look at the number of cold viruses you have all disposed of. In fact, it is becoming increasingly difficult to die of infection, in this part of the world at any rate.

It is hard to say when a disease is endemic and when it becomes epidemic. It is not unusual to have 500,000 cases of smallpox in China. What a small part would we designate in this country as epidemic.

Evidently there have been in the past many parasites which have disappeared or become so weak that they cause little trouble. In some cases man has developed enough immunity to overcome them. Those which live part of their existence outside the human body have disappeared from parts of the world at least, because of changes in the climate. There seem to have been areas, formerly blessed with a big rainfall where mosquitoes and therefore malaria flourished. Now they are deserts.

Although we have heard much of the ignorance and superstition which ruled the public reaction to great epidemic the public often showed a deal of sense. Thus in visitations of the plague those who could moved out of town. I know of nothing better which they could have done. Of course some of the group were pretty apt to carry the plague with them but the more they dispersed the better their chances were.

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BOOK REVIEWS

concluded from page 295

None of our stinking ancestors liked the smells which they had to endure, but just as we have been slow to get rid of our smoke they slowly eliminated their smells. What a holier than thou attitude for the people of Providence to take to heap scorn on the people of London or Edinburgh because the latter also reeked with vile odors some centuries ago.

Although the reason for getting rid of smells was wrong, the result was right, for it was human feces which smelt worse and which were most dangerous. The Roman sewers were marvels and it is truly remarkable that they could have been forgotten or ignored for so many centuries. Their latrines were also admirable although lacking the "finger tip control" of so many of our foolish modern gadgets. Even today our big cities are far behind in their system of public latrines. One thing that helped was that they felt no need to "pander to a desire for privacy." It was the Roman custom to answer the calls of nature in company. "26 carved seats with dolphins as ornamentation" would have been at once the despair and delight of Chick Sales of three-seater fame.

The personal cleanliness of the Greeks and Romans sank into innocuous desuetude for centuries. And typhus and its cousins flourished.

Do not think that we are now happily secure in our hygiene. Humanitarians tell us that we had no moral right to carry the White Man's Burden. We are rapidly discarding it leaving it to be taken up by not a very husky group. One of the biggest items is labeled hygiene. It is an awkward thing to carry. There is reason to doubt if it will be well handled.

One pessimistic Indian has remarked that perhaps it is better for the great hordes there to die quickly of tuberculosis rather than slowly waste away with starvation.

This book has not given the answer. But it has certainly stated the problem clearly.

PETER PINEO CHASE, M.D.

VIRUS DERMOTROPI E MALATTIE DA VIRUS IN DERMATOLOGIA by C. Scarpa. S. Pipola, Napoli, 1953. Lire 1000.

The volume puts together what is known at present clinically and experimentally about viruses in diseases of the skin. It comes to the conclusion that a good number of cutaneous diseases, of unknown etiology, may be due to a virus.

Data are scattered in the literature in an enormous quantity of papers. The student interested in the subject will have at hand in this monograph a good selection of publications to receive inspiration for original work.

F. RONCHESE, M.D.

CHILD GUIDANCE CLINIC CITED

At a recent meeting of the American Association of Psychiatric Clinics for Children, the training committee, council and membership voted unanimously for the approval of the Providence Child Guidance Clinic as a training center for psychiatrists in child psychiatry, one of only thirty-five such centers in the country so approved.

The fellow in training will also take part in the training facilities of Butler Hospital and other Rhode Island psychiatric units.

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and

GOLF TOURNAMENT

Wednesday . . . June 15

The Providence Medical Association

at the

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BRONCHIAL ASTHMA

During the asthmatic attack, the bronchial wall is contracted and the lumen is narrowed and further obstructed by thick, tenacious mucus.
THE MERCK MANUAL, 8TH ED. 1950.



FOR MORE RELIEF IN BRONCHIAL ASTHMA

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IN EACH SCORED TABLET

AMINOPHYLLINE . . . . . **2 GRS.**

EPHEDRINE HCL . . . . . **¼ GR.**
For spasm relief and dilation of bronchioles

PHENOBARBITAL . . . . . **⅓ GR.**
For mild sedation

POTASSIUM IODIDE . . . . . **3 GRS.**
To liquefy and drain distressing mucus plugs

ISSUED IN BOTTLES OF 36 AND 100 TABLETS

DOSAGE: *One tablet, with full glass of water, 3 or 4 times a day*

Recently most investigators state that viscid mucus, even more than spasm, is responsible for asthmatic wheezing and dyspnea. Mudrane relieves asthma by liquefying and draining this mucus as well as by dilating and relaxing the bronchioles. Mudrane is buffered for tolerance and is accurately formulated for maximum relief without side-effects.

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Lactogen®

...long recognized for outstanding results and economy in infant feeding

- Unusually well tolerated and easy to digest because of zero curd tension.
- Assures optimal growth and development, since it contains one-third more protein than does breast milk.
- Reinforced with iron and fortified with vitamins A and D.
- May be prescribed with confidence even for prematures.
- So convenient, easy, and safe to prepare. Simply stir into previously boiled water.

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A natural all-milk formula, Lactogen is modified with milk fat and milk sugar to approximate the fat and carbohydrate composition of breast milk. It is pasteurized, homogenized and spray dried. In addition to supplying one-third more protein than does breast milk, Lactogen is naturally higher than breast milk in vitamin B_6 and is fortified with vitamins A and D and iron. Yet Lactogen provides all these vital nutritional needs at remarkably low cost.

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without the undesirable effects associated with the usual opiates or their derivatives commonly employed in cough control.

Toclase Syrup
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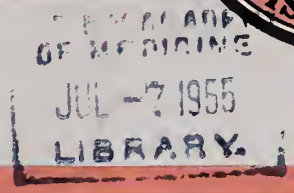
RHODE ISLAND MEDICAL JOURNAL

JUNE, 1955

THE LUNG CANCER SUSPECT

See page 319





For those who develop nasal congestion on reserpine therapy . . . prescribe

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—relieves nasal stuffiness in 75 percent of patients who experience this annoying side-effect. Each tablet combines 0.25 mg. 'Sandril' and 7.5 mg. 'Pyronil.'

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to work...and every
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With accurate diagnosis
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the majority of epileptics,
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on a normal life.

DILANTIN® SODIUM (diphenylhydantoin sodium, Parke-Davis)

a mainstay in anticonvulsant
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choose all three

- **a musculotropic drug** to relieve intrinsic muscle spasm within the muscle cell
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Trocinate with phenobarbital relieves spasm by a comprehensive, three-way action. Trocinate exerts both strong musculotropic and neurotropic effects, as proved by extensive pharmacologic studies.[1,2] Clinically, Trocinate has been stated to be an effective antispasmodic in spastic colitis[3,4] and in biliary dyskinesia,[3] peptic ulcer,[4] pylorospasm,[4] gastroenteritis,[4] gastrointestinal irritability,[4] and in spasms of the bladder and ureter.[2] Average dosage of Trocinate (1 grain) with phenobarbital (¼ grain) is one tablet, four times a day. Trocinate (1½ grains) is also issued *without* phenobarbital for more intensive antispasmodic therapy.

1. J. Pharm. & Exp. Ther., 89:131
2. J. Urology, 73:487
3. J. Mo. Med. Assoc., 48:135
4. Med. Rec. & Annals, 43:1104

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Meat...

Dietary Cholesterol and Vascular Sclerosis

Recent studies reaffirm the "hypothesis that atherosclerosis is fundamentally a metabolic disease subject to important dietary influences"[1] and do much to refute contentions that foods containing cholesterol should be avoided in general diets.

Arterial disease resembling that in human subjects was produced in Cebus monkeys fed diets high in cholesterol and low in sulfur amino acids. Within 2 to 8 weeks after initiation of the regimen serum concentration of cholesterol rose to levels of 300 to 800 mg. per 100 ml. "The hypercholesterolemia could be largely prevented by feeding 1 gram per day of dl-methionine or l-cystine as supplements to the diet." Also, the elevated cholesterol levels "could be restored to normal by feeding 1 gram of dl-methionine but only partially restored by 0.5 gram of l-cystine daily."

According to the investigators, the "vascular lesions were in the ascending aorta but extended from the valves of the left ventricle to the proximal portions of the carotid and femoral arteries . . . The aortic lesions were chiefly characterized by the presence of lipid-laden phagocytes and increase in collagen and elastic fibers. The lipids were in part cholesterol derivatives."

Cholesterol, an essential metabolite produced in intermediary metabolism,[2] is biosynthesized from dietary protein, fat, and carbohydrate.[3] Normally, its synthesis is exquisitely controlled to insure adequacy as well as to protect against an oversupply.[4] Furthermore, considerable evidence indicates that an increased cholesterol intake is not an etiologic factor in alleged aberrations of cholesterol metabolism such as atherosclerosis.

In widely variable amounts, cholesterol occurs in foods of animal origin—meat, poultry, fish and marine foods, eggs, milk products—all foods of great nutritive value.[3] Present knowledge in no way warrants alteration in the customary consumption of these foods because of their contained cholesterol.

Skeletal muscle of beef, lamb, pork, and veal provides but small amounts of cholesterol, approximately 0.06 Gm. per 100 Gm. moist weight of meat.[5] Since atherosclerosis may interfere sharply with normal nutrition, the patient should consume diets rich in protein foods (such as meat), vitamins, and fruit.[6] In addition to high quality protein, meat supplies valuable amounts of needed B vitamins and essential minerals.

1. Mann, G. V.; Andrus, S. B.; McNally, A., and Stare, F. J.: Experimental Atherosclerosis in Cebus Monkeys, J. Exper. Med. *98*:195, 1953.
2. Okey, R.: Use of Food Cholesterol in the Animal Body; Relation of Other Dietary Constituents, J. Am. Dietet. A. *30*:231 (Mar.) 1954.
3. McLester, J. S., and Darby, W. J.: Nutrition and Diet in Health and Disease, ed. 6. Philadelphia, W. B. Saunders Company, 1952, pp. 517-518.
4. Editorial: The Biosynthesis of Cholesterol, J.A.M.A. *152*:1435 (Aug. 8) 1953.
5. Okey, R.: Cholesterol Content of Food, J. Am. Dietet. A. *21*:341 (June) 1945.
6. Wright, I. S.: Arteriosclerosis, in Stieglitz, E. J.: Geriatric Medicine, Medical Care of Later Maturity, ed. 3, Philadelphia, J. B. Lippincott Company, 1954, chap. 28, p. 413.

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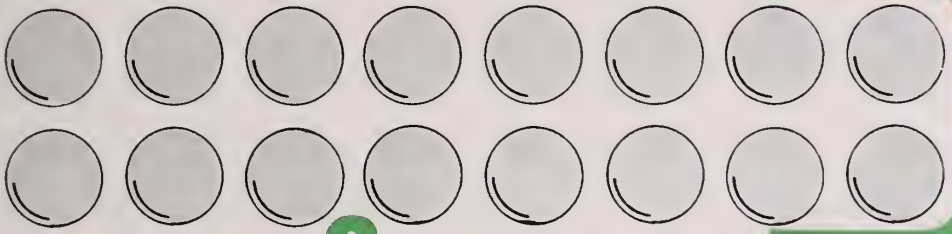
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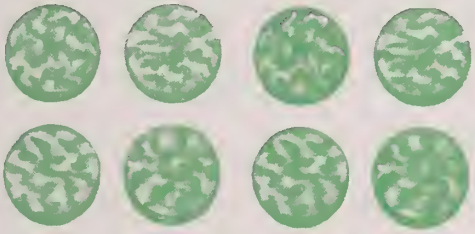
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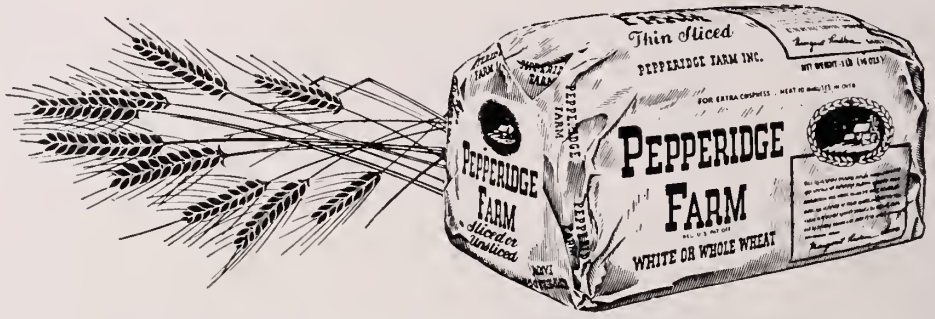
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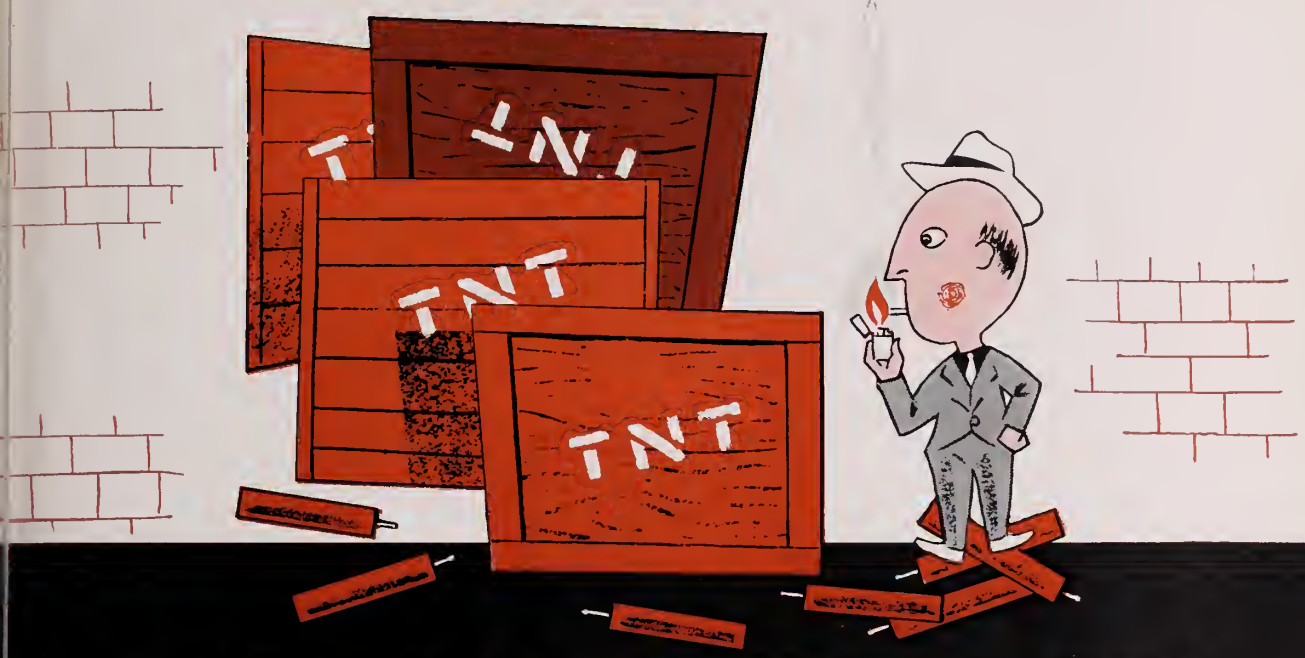
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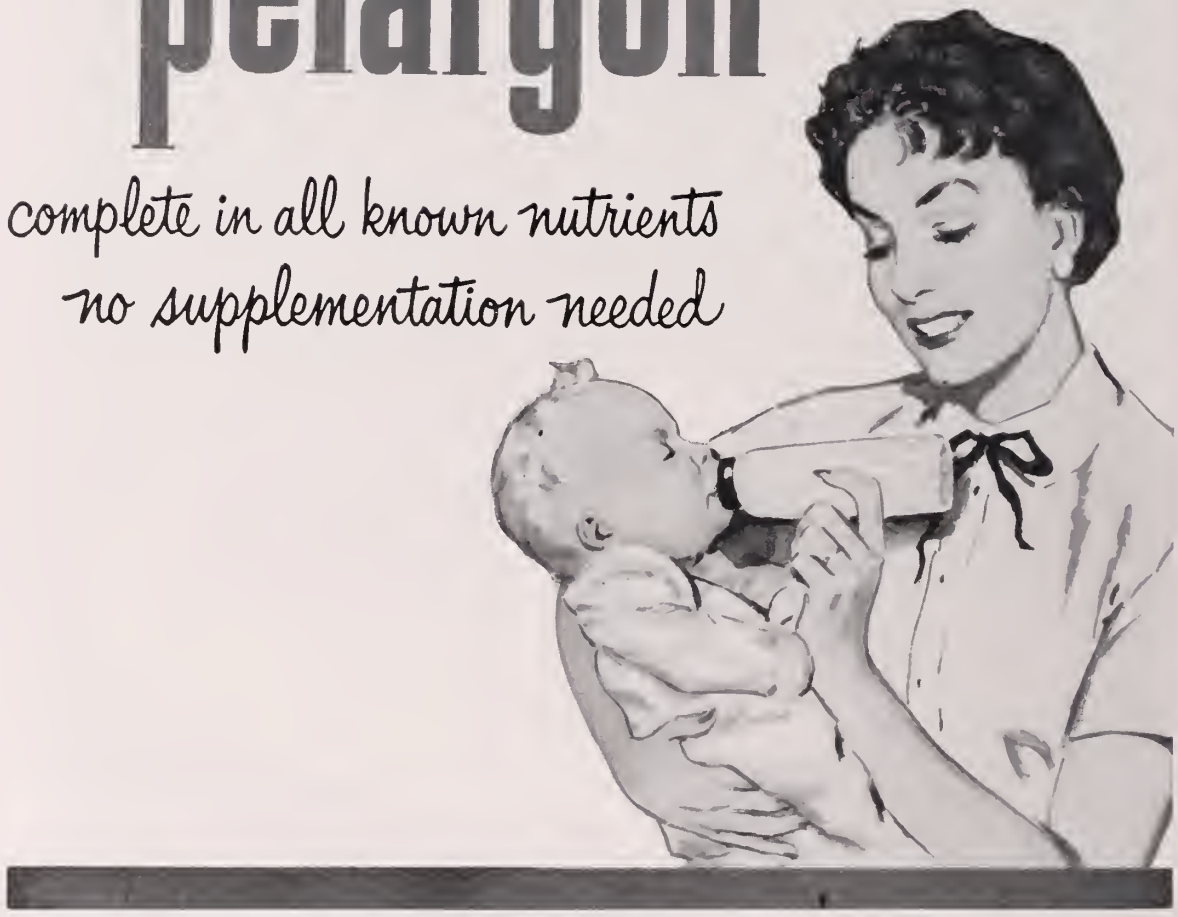
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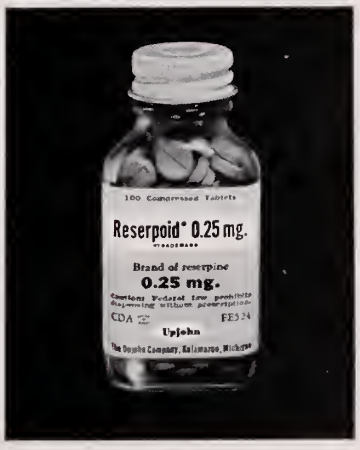
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXVIII JUNE, 1955 NO. 6

THE LUNG CANCER SUSPECT

A Problem in Identification and Management

WALTER E. O'DONNELL, M.D. and EMERSON DAY, M.D.

The Authors. *Walter E. O'Donnell, M.D., Assistant Director, and Emerson Day, M.D., Director, The Strang Cancer Prevention Clinic, Memorial Center, New York, New York.*

IN PRESENT DAY efforts to control lung cancer, the practicing physician occupies a unique position of opportunity and responsibility. It is to his hands that the potential chest tumor suspect usually first comes from one of several sources:

First, there is the symptomatic patient who presents himself for evaluation because of symptoms which may be minimal or may be full-blown and characteristic of the disease. It is the former category, the early symptomatic patient, which represents the most frequent responsibility and challenge for the private physician.

Second, there is the patient drawn from the increasing number of persons who present themselves at the doctor's office for a "general check-up." Here, alertness to subtle leads on examination and insistence on a routine chest X ray will uncover many otherwise unsuspected pulmonary lesions.

Third, tumor suspects are culled from the more than twenty million Americans who are hospitalized annually.[1] The routine admission chest film, standard practice in many institutions, singles out a number of these for special attention because of an unexplained X ray shadow.

Fourth, the doctor is often confronted by the patient, symptomatic or asymptomatic, who is referred for diagnostic evaluation because of an abnormality detected on a chest X ray taken as part of a mass population survey, or in connection with application for employment, etc.

In all of these instances, it is the practicing physician who to a large extent determines how extensive and intensive the diagnostic evaluation will be, how fast it will be accomplished, and how soon the patient will be referred for definitive surgery.

Certainly the magnitude of the present day lung cancer problem and, more alarming yet, its future potential need no re-emphasis here. The fact remains after allowances have been made for the increased age of the population and all other variables, including increased diagnostic accuracy, that during the last two decades the mortality due to lung cancer has increased four to five fold among males and has more than doubled among females.[2,3] Pending further delineation of the environmental factors involved in lung cancer and the subsequent development of preventive measures, the responsibility of the medical profession is to make maximum utilization of the presently available methods of diagnosis and treatment which give promise of some effectiveness when properly applied.

Present Status of the Lung Cancer Problem

The evidence for this potential effectiveness is contained in a review of the present status of the lung cancer problem and a comparison of the average experience with the few recorded series of cases in which near-ideal management of the tumor suspect has been achieved. Because of the extreme variability in the criteria employed at various institutions with reference to operability, resectability,

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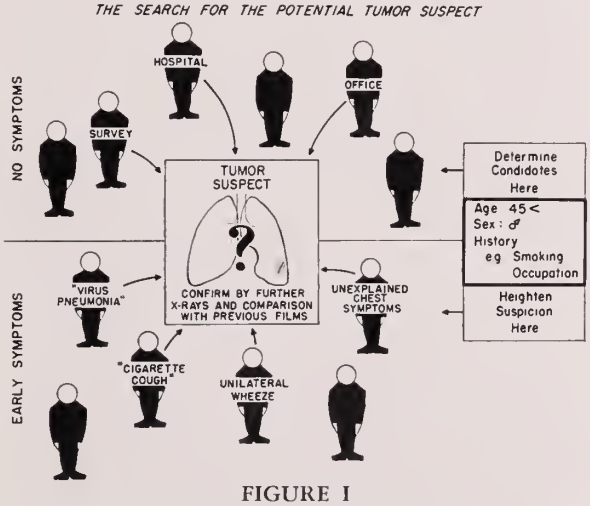


FIGURE I

The Search for the Potential Tumor Suspect

and survival, as well as the different methods employed in reporting results, this can probably best be accomplished by using a hypothetical series of 100 cases in each category for purposes of illustration. This is schematically represented in Figure II.

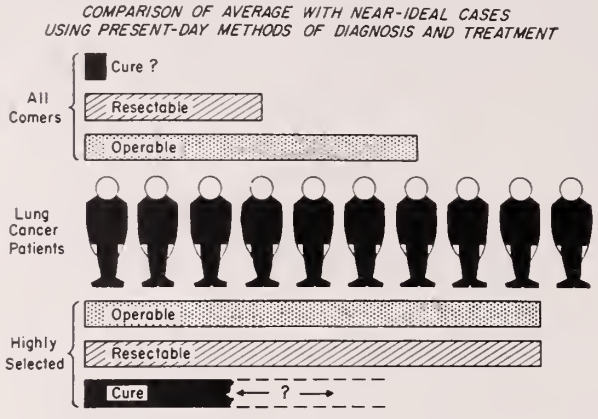


FIGURE II

Comparison of Average with Near-Ideal Cases Using Present Day Methods of Diagnosis and Treatment

It is realized that the figures used are rough approximations, but if this is kept in mind, they are representative enough for purposes of broad interpretation.

First, in a hypothetical series of 100 totally unselected cases of lung cancer, approximately:

65 cases will be operable
30 cases will be resectable
5 cases will be "cured"

On the other hand, in a series of 100 cases of lung cancer detected by routine chest X ray and promptly treated, approximately:

90 cases will be operable
90 cases will be resectable
35 patients will be "cured"

The over-all survival rate of the second hypothetical series leaves considerable to be desired, but it is readily apparent that there is a striking difference in the "curability" of the two groups. What is the reason for this marked discrepancy? The answer to this question can be found in the difference between detection on the one hand and diagnosis on the other.

Detection is the diagnosis or the creation of suspicion leading to the diagnosis of lung cancer in the asymptomatic patient, in contrast to diagnosis initiated in the symptomatic patient. Admittedly, there are individual exceptions in these hypothetical series. An asymptomatic patient with a small lesion subjected to speedy and adequate surgery may fail to live out the year, while an occasional patient with a large bulky lesion subjected to a series of diagnostic delays may live for a number of years without treatment or with inadequate therapy. But the principle that detection of presymptomatic lung cancer offers the greatest likelihood of resectability and cure is a sound clinical premise.

That the near-ideal differs from actuality is readily attested to by the fact that in most large series of lung cancer cases asymptomatic patients almost invariably constitute less than 5% of the total[4, 5] and are sometimes reported as low as .5%.[6] Furthermore, in a number of the asymptomatic or survey-discovered cases of bronchogenic carcinoma, it is conceded that a signifiant number of the patients developed symptoms attributable to the lesion during the delay period before surgery.[7] As has been indicated, the reason for the impressive difference in prognosis following treatment between the asymptomatic or survey-discovered lung cancer and that of the general run of cases is the much higher percentage of the former which are found to be resectable at the time of operation. This once more emphasizes the need for extending the use of measures which can increase the number of patients with lung cancer in the asymptomatic and potentially curable group at the time they are first seen by the thoracic surgeon.

The Search for the Lung Cancer Suspect

While the private physician represents the ultimate control point in the diagnosis and management of the patient with lung cancer, the search for the potential tumor suspect has also been undertaken at the community and hospital levels, where the mass chest survey and the routine admission film have been employed as screening procedures. These will be reviewed briefly since they contribute some helpful points to our understanding of the over-all problem.

The Community—Mass Surveys

X ray examination of the chest has constituted the only medium seriously considered for application as a screening or mass survey technique to presumably asymptomatic persons, i.e., true detection. These mass surveys have always been regarded primarily as tuberculosis case finding efforts and lung cancer included as an incidental, but important, by-product. For this reason, many of the serious defects attributed to surveys, particularly with reference to their yield in proportion to the effort expended, can be explained entirely on the tremendous dilution factor provided by the thousands of persons screened who have virtually no lung cancer potential.

It was hoped that by analyzing the application of the chest X ray to population groups numbering hundreds of thousands—in one survey nearly two million—that an answer could be provided to these two pertinent questions:

How much lung cancer will be picked up?

Will these patients have a better chance for cure?

Unfortunately, no absolute answer is possible to either at present. As far as the first question is concerned, the results of two large, fairly representative surveys can be reduced to simplified form as follows:

Boston[8]	Los Angeles[9]
(536,012 persons)	(1,867,201 persons)
1 suspect: 1350 persons	1 suspect: 500 persons
1 cancer: 10 suspects	1 cancer: 16 suspects
or	or
1 cancer: 13,500 persons	1 cancer: 8,000 persons

In addition to the relatively low yield, the results of management of these survey-discovered lung cancers are somewhat disappointing. Of the 39 confirmed bronchogenic carcinomas reported by McNulty in the Boston survey, 28 patients were subjected to operation. Of these, 22 were resected and at the end of 3 years, only 5 were alive.

The Los Angeles experience was more favorable. Of the 213 cases of bronchogenic carcinoma reviewed by Guiss, 53% were operable. Of the latter, 75% were resectable and 35.8% were alive at the end of 3 years. The absolute three-year cure rate, however, based on all cases, was only 11.3%.

A more concrete idea of the wide discrepancy between the near-ideal and the average can be obtained from two smaller series:

	Survey-Discovered Carcinoma[7] (Overholt Clinic)	Asymptomatic Carcinoma[4] (Mayo Clinic)
Total Number	30	29
Explored	26 (87%)	29 (100%)
Resected	23 (77%)	29 (100%)
3-Year Survivors	9 (30%)	*

*15 (52%) living at periods up to a maximum of 7 years after operation; however, nearly all have been followed less than 3 years.

Some of the reasons for the relatively disappointing result with regard to pick-up and salvage resulting from mass population surveys are readily apparent:

1. Age: Up to two-thirds of persons were under the age of 40.
2. Sex: Females accounted for two-thirds of some surveyed groups.
3. Delays: Months often elapsed from suspicion to actual treatment.
4. Symptoms: Persons surveyed or cases picked up were often symptomatic.
5. Non-smokers: These persons, with little chance of lung cancer, made up an unknown, but significant, percentage of those screened.
6. "Single Shot": The initial survey often "detects" advanced cases and may miss very early cases. It must be a repetitive procedure.

From the strict standpoint of lung cancer control, the most meaningful figures will be those which deal with pick-up and prognosis after prompt treatment of lesions resulting from periodic chest X rays in asymptomatic males over age 45, especially those with a history of long-term heavy smoking. Until a breakdown is possible on mass surveys or a model survey which takes cognizance of these factors is reported, no realistic appraisal of the true value of X ray surveys for lung cancer is possible.

The Hospital—The Admission Chest Film

More than 20,000,000 persons are admitted to general hospitals in the United States each year. Insistence on a routine chest film on entry could be expected to screen a significant portion of the population for lung cancer as well as for other intrathoracic disease. In this country, nearly one-half of hospitals with 250 patients or over have facilities for routine X rays on all admissions and the idea is gaining in acceptance.[10] However, when smaller hospitals are taken into consideration, only slightly over one-quarter of all admissions have this available.

An idea of the productivity of such a hospital screening program can be obtained from a recent New York State Health Department study dealing with pick-up of intrathoracic tumor suspects on hospital admission films:[11]

All Ages	Rate/1000
Total	4.4
Male	8.2
Female	2.5

Even more revealing is the analysis of yield in susceptible age groups:

Age 45 and Over	Rate/1000
Male	13.6
Female	6.9

This is based on 254,549 patients, 15 years of age or over, who had admission chest films in New York State in 1953. Results of follow-up are not yet available but several small spot checks of results indicate that about 10% of the suspects are eventually found to have bronchogenic carcinoma.

The Private Office—The Routine Chest Film

The private physician can increase the total of asymptomatic lung cancer detected by promoting the use of the routine chest film for his patients, particularly those who fall into the categories having the greatest lung cancer potential. This highest risk group consists of men over the age of 45 with a history of long-term heavy cigarette smoking[12] or certain occupational exposures.[13]

Two points are worthy of emphasis:

1. For the high risk group, the chest X ray must be a repetitive or periodic effort undertaken on at least an annual basis. Many patients have become oriented to the value of this procedure. For the patient who cannot afford periodic chest X rays these can be obtained through public facilities in many communities.

continued on next page

2. It should be underscored that chest fluoroscopy is not a dependable method for the detection of the relatively minute and subtle changes of early lung cancer, or its differential diagnosis from other lesions. Once the suspicion has been raised by conventional X ray films, however, fluoroscopy may be of considerable aid in experienced hands.

The fact that added dividends in the form of other unsuspected chest pathology may be expected as a result of the routine chest film scarcely needs reiteration.

Management of the Lung Cancer Suspect

It is not our intention to enter into a lengthy discussion of the differential diagnostic aspects of the lung cancer suspect, but rather to outline a suggested series of diagnostic steps, point out a few of the errors and pitfalls commonly encountered, and once again to emphasize the necessity for an attitude of urgency and decisiveness on the part of the physician carrying out the evaluation. Certainly, there is no lack of diagnostic adjuncts that can be brought into play in evaluation of the tumor suspect; in fact, it often seems that their very multiplicity contributes to delay and mismanagement. Whether the patient is symptomatic or asymptomatic, it seems likely that the prognosis could be measurably improved in most cases if the gap were narrowed between detection or diagnostic procedure, the creation of suspicion, the establishment of the diagnosis, and the ultimate plan of treatment. An attempt has been made in Figure III to compare roughly the relative value of the various methods of diagnosis, realizing that they frequently overlap and that there is no absolute "best way" for all cases.

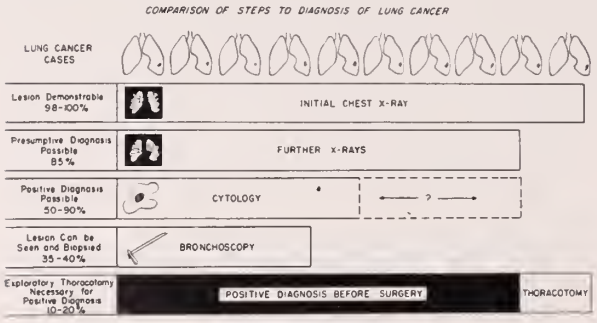


FIGURE III
Comparison of Steps to Diagnosis of Lung Cancer

The steps outlined below should be taken only as a general framework which can and must be altered to fit the individual case. Most of them can be carried on almost simultaneously, or at least in rapid succession. Several of them should have no proper role in the management of many lung cancer suspects, but are included for the sake of completeness.

1. Complete history and physical examination. This is true primarily of those lung cancer suspects who have their origin in the mass survey, since this step will presumably already have been acomplished in the other categories.

II. The taking of confirmatory films to reaffirm the presence of a significant lesion. Comparison with previous films, if these are available, is a particularly helpful procedure in evaluating the significance of such a lesion.

III. Cytologic examination. Application of the Papanicolaou technique to the study of sputum and tracheal and bronchial washings has come to the forefront in recent years, and has proved to be more frequently successful than bronchoscopy with biopsy as a means of establishing a morphologic diagnosis. Taken together with bronchoscopy, it has reduced the number of pre-operatively undiagnosed lung cancer cases to less than 20% of the total. In expert hands, this method by itself can yield a positive diagnosis in as high as 90% of cases.[14, 15]

The figures reported regarding cytology usually include diagnoses made by bronchial washings done at the time of bronchoscopy. However, it is the feeling of many experienced cytologists that examination of a representative sample of sputum is equally satisfactory. The fact that such a sample can be obtained for diagnosis without the necessity of bronchoscopy adds to its usefulness. Furthermore, it is often possible to postpone bronchoscopy for the patient with a highly suggestive pulmonary lesion and a positive cytologic diagnosis of cancer until the immediate pre-operative period. Probably the most important aspect of cytology as a diagnostic aid is the fact that it is a procedure which can be instituted by the private physician in his office on the first day the patient is seen, and the collection of adequate specimens can be carried out concomitantly with radiography and such other studies as may be necessary.

In collecting sputum for cytologic study it is important that the specimen be the product of deep coughing and as free as possible of admixed saliva. The most satisfactory specimens are those obtained soon after arising in the morning. The sputum is expectorated directly into a bottle containing 70% alcohol, or 70% alcohol may be added to the specimen within three hours after expectoration. If sputum is scanty, it is advisable to collect it on three consecutive mornings in separate specimen bottles.

At least three satisfactory sputum specimens should be submitted before a negative cytologic report can be considered reliable. However, as with all such procedures, more diligent efforts may at times be warranted, since occasionally it is found that the first positive specimen is reported after six or more negative studies. The one big drawback to the full exploitation of the cytologic diagnosis of

lung cancer has been the lack of laboratories and of pathologists experienced in pulmonary cytology. With the increasing demonstration of this as the single most effective diagnostic procedure aside from the chest X ray itself, it can be anticipated that this problem will yield to current efforts to extend the availability of cytologic services.

IV. Bronchoscopic examination. Bronchoscopy is traditionally the procedure which first comes to mind when the possibility of lung cancer is entertained. The fact is probably worthy of re-emphasis, therefore, that in only about one-third of all lung cancers can the tumor be visualized bronchoscopically and a biopsy diagnosis obtained preoperatively.[6, 15, 16, 17] This is determined primarily by the location of the particular lesion. As a general rule, the smaller and earlier (more favorable) tumors are least likely to be accessible for bronchoscopic biopsy.[15] In cases in which the X ray picture makes it highly likely that the lesion is an inaccessible one or in cases with positive cytologic evidence, it may be possible to postpone bronchoscopy until the more immediate preoperative period as mentioned above.

V. Differential diagnostic studies. These include: *A.* X ray: tomography, laminography, fluoroscopy of the chest, with or without barium swallow, bronchography, and angiocardiography may be required. The indication for these, again, varies with the particular case at hand. *B.* Others: Various diagnostic procedures including bacteriologic and agglutination studies, skin testing, etc. depending on the disease entities considered, may be carried out. The type and number of these varies widely with the individual case.

VI. Exploratory or diagnostic thoracotomy. In up to 20% of all lung cancer cases the diagnosis can be arrived at only by operation. This procedure, in the hands of an experienced surgeon, is accompanied by an acceptable risk of morbidity and mortality and, considering the potential of the lesion involved, does not deserve the reluctance with which it is generally recommended or resorted to. It is frequently far preferable to many of the complicated, expensive, and, above all, time-consuming diagnostic studies possible. In almost all instances, the diagnosis of lung cancer can be rejected or confirmed or the decision for exploratory thoracotomy made within one month—frequently in much less time.

Fallacies and Pitfalls

A few of the common fallacies or pitfalls in the management of the lung cancer suspect must be mentioned:

1. Repetitious diagnostic procedures. As has been indicated above, it is possible to do grave disservice to the welfare of the patient by repetitious X ray studies, bronchoscopies, and cytologic examinations, and by placing unreasonable emphasis on the necessity for a biopsy or even cytologic diagnosis before any surgery is undertaken.[18]

2. "Virus" or atypical pneumonia. What Overholt refers to as the "red herring" of virus or atypical pneumonia has resulted in many outstanding examples of delay while the effect of observation and antibiotic therapy has been studied.[18] It is important to remember that merely because a suspicious pulmonary lesion regresses during this period does not *de facto* establish the diagnosis of virus or atypical pneumonia, since the obstructive pneumonitis often associated with bronchogenic cancer may do likewise, at least temporarily.[19] Again here, the facts in the individual case must determine management, but an unexplained pulmonary lesion especially in a male over the age of 45 is cancer until proven otherwise.

3. The "old" pulmonary shadow. As has been indicated, comparison with previous chest films both for the presence of the lesion and any possible change over a period of time is often helpful. Yet the very fact that a lesion is of long duration, and even the fact that it may not have changed significantly, does not always positively exclude cancer. The retrospective studies of Rigler and his coworkers tend to confirm the fact that lung cancer may be considerably more "chronic" than is generally realized.[20] By way of example, they refer to two extreme cases: one in which the earliest X ray evidence of the disease was noted nine years before the death of the patient, and another in which it was demonstrated four and one-half years before the onset of symptoms. Furthermore, the asymptomatic solitary, circumscribed, "coin lesion" has been found to be malignant in a relatively high percentage of cases,[21, 22] especially in the older age groups.[23]

4. Calcification. That the presence of calcification within an unexplained pulmonary lesion increases the likelihood of its being benign is a well-recognized observation. However, calcification has been found in cases of lung cancer both pathologically and roentgenographically.[24] Here again, clinical judgment must over-ride any "rules of thumb" and one should not hesitate to employ diagnostic thoracotomy if suspicion is aroused.

SUMMARY

Present day efforts to identify the potential lung cancer suspect in the community, hospital, and private practice population have been reviewed.

The importance and feasibility of detection and early diagnosis of lung cancer in the localized, surgically-treatable stage has been evaluated.

A general program for management of the lung cancer suspect by the practicing physician has been outlined and some of the inherent problems touched upon.

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MEETING OUR PLEDGES

HENRI E. GAUTHIER, M.D.

The Author. *Henri E. Gauthier, M.D., President, the Rhode Island Medical Society, 1954-55.*

SHARING in the glory and tradition of what is considered to be the oldest and noblest profession should excite in everyone a sense of selfish pride as well as a challenge to guard jealously the honorable bequests, the prestige and the scientific endowments that we inherit.

Individual honor and prestige can only be acquired by a very slow and methodic manner but might be shattered very abruptly by the least deviation. Honor and prestige of the medical profession have been built up through the centuries, are maintained by concerted action and untiring efforts and are little if at all affected by individual wanderings.

To those outside of the profession we stand out as a very specially privileged and very much favored group, deserving of every trust and confidence without any thought that such privileges, trusts or confidences will ever be betrayed, and rightly so.

Our position is unique. We are all adherents to a self-promulgated, self-imposed, and self-controlled honor system, both in purpose and effect. This system has stood the test of centuries. In fact, it had its inception with Hippocrates, the Father of medicine and the greatest physician of ancient times, about twenty-three hundred years ago. As we know, Hippocrates was a prolific writer and the following works have passed from generation to generation: "Prognosis," "Aphorisms," "On Epidemics," "On Diet in Acute Disease," "On Air, Water and Place," "On Wounds of the Head"; but the oath of Hippocrates, a self-imposed code of ethics for himself and his followers, has remained as a masterpiece and through the ages has been adopted.

In essence, this oath recites a traditional approach to our duties and to our directives in five distinct articles.

The first article spells a grateful appreciation for the knowledge received and I quote, "to reckon with him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring on the same footing as my own brothers, and to teach them this Art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none other."

The second article is a guarantee of an honorable conduct, to wit—"I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art." And I continue, "Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption."

The third article is an elaboration of an old Greek proverb—"Ovauti eeautov," which translated means—"Know Thyself," and I might add "and thy competence and limitations." Hippocrates stated it this way in his oath—"I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work."

Special concern for professional confidence is mentioned in the fourth article, as follows—"Whatever, in connection with my professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge as reckoning that all such should be kept secret."

Finally in the fifth and last article, Hippocrates solicits respect and prestige if he is deserving of it, but if not, he is willing to pay the penalty, and I quote—"While I continue to keep this Oath inviolate, may it be granted to me to enjoy life and the practice of the Art, respected by all men in all time. But should I trespass or violate this Oath, may the reverse be my lot."

Elsewhere in his writings, Hippocrates discourses on one's manners and conduct, advising discretion, soberness and mental reservation. He

*Presidential Address delivered at the 144th Annual Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, May 4, 1955.

points out certain attitudes that are considered to be intolerable, such as in the following excerpt—"Who on the other hand laughs readily, becomes a burden whence this is particularly to be avoided."

Categorically, the medical profession is more than observing the pledges contained in the oath of Hippocrates and infractions are the exception and only of rare occurrence.

Approximately one hundred and fifty years ago, Rene Laennec, the French physician and anatomist, and discoverer of the stethoscope, in his "Memento" drew up sixteen articles concerning the relations between physicians and patients as well as the relations of physicians among themselves. The French physicians upon receiving their degree in doctor of medicine must swear not only by the oath of Hippocrates but as well by the oath of Laennec.

The most important articles* in this oath pinpoint the physician's obligations more specifically:

"1. In the accomplishment of my duties I will thereby prove that God is my Sovereign Master.

"2. In my profession I will be faithful to all precepts of moral and medical honor.

"3. I will give to my patients devoted and conscientious care; and with that objective in mind I will strive to perfect my knowledge according to the progress and modern practice of medical science.

"4. I will consider it to be a grave obligation to respond to sick-calls.

"5. I will not divulge any professional confidence.

"6. I will exert all my influence to combat theories and practices of neo-malthusianism.

"7. Life being a sacred thing, I will treat it with sovereign respect.

"8. I will consider it to be a duty or cause someone else to warn with the most delicate discretion, a patient who is gravely ill so that he may put his material and religious interests in order.

"9. Never will I demand honoraria above one's financial status.

"10. Upon my honor, I will never accept any amount of money that is not a just retribution of a professional act.

"11. With all my heart, I will strive for the religious, moral and material good of the medical profession.

"12. On all occasions, I will strive to be most loyal, and devoted to all professional activities.

"13. I will conduct myself according to the principles of Good-fellowship towards my fellow physicians.

"14. I will be charitable towards the poor."

(*Two articles have been purposely omitted. They are pledges to a local Medical Society in Paris and to medical progress, respectively.)

Extensive bibliographic research failed to uncover any other oath that has been adopted.

There are pledges however that transcend the oaths of Hippocrates and Laennec and they are dictates of moral ethics and natural law. More specifically, they are the guiding principles of one's conscience and therefore are inescapable directives. The Hippocratic and Laennec oaths are outward pledges, but the dictates of moral ethics come from within and therefore are prescriptions from one's soul. We pledge our allegiance to the oaths, whereas the dictates from our conscience are a challenge to our honor. These imply that we uphold according to our ability and judgment an upright conduct at all times, respecting fully the moral inherited, as well as acquired rights of those to whom we render care.

I have been referring to a section in deontology which is the science or theory of duty or of moral obligation. More succinctly, deontology is the ethics of duty.

It is possible to group under three general principles of natural right or law, with more or less ease, all the duties and obligations of the physician that should guide him in his daily conduct. These are the principles of justice, of charity and of prudence.

Let us consider briefly each one of these directing or guiding principles. Undeniably the majority of our professional obligations and duties are derived from the fundamental principle of justice which is founded on the axiom that "it is forbidden to violate the precise rights of others and it is decreed that we shall render fully to each one his just due in keeping with his natural or moral rights as well as his acquired rights." More simply expressed, we are bound to render to each one his due without ever violating the rights of anyone.

To discuss at length all the moral obligations that come under the principle of justice alone would require more time than has been allotted to me, however, taking but a bare glimpse and without the least elaboration, this principle presupposes a minimum of six specific moral obligations and moral observances.

I would like to take but a minute to recite some of the duties dealt with under the first obligation and I list them briefly:

Of the requisite of adequate preparation, foundations, knowledge and ability;
of continued study;
of keeping up to date;
of availing one's self of all the opportunities to increase one's knowledge;
of imparting knowledge to others;
of enlightening our patients in a satisfactory manner and in understandable language;
of becoming a member of medical societies;

continued on next page

of attending meetings; and
of contributing to meeting, societies and social welfare.

The list is much longer, but what has been said will give you some insight into our moral duties under the principle of justice.

It is evident that relying on trial and error or on personal experience, rather than on acquiring knowledge by attending courses and meetings, never has been condoned by the moral obligations listed under the principle of justice.

In dealing with the moral obligations, failure of knowledge is no more an excuse than ignorance of the law in civil matters.

The noble principle of charity prescribes that we love our neighbors as ourselves, forbids that we do unto others that which we would not have anyone do unto us and decrees that we desire and procure effectively for others, irrespective of station, all the good and welfare that we would reasonably wish for ourselves. It is only fair that we treat others as we would like to be treated by them.

All the duties of the physician are derived from the principles of justice and of charity. However, they are under the constant guidance of the principle of prudence. It is to be conceded that the principles of justice and charity cannot be fulfilled ethically without complete understanding and application of the principle of prudence. The axiom that lends itself to the principle of prudence is that "kindness and honesty are repaid one hundred fold." Or in other words, the proper application of foresight will never cause regret. It therefore is apparent that prudence which also implies discretion, carefulness, calculation, wisdom and common sense, is an indispensable attitude in observing the duties and in the fulfillment of the obligations under the principles of justice and charity. No one can dispute that justice, charity and prudence have their recompense, and as was so aptly stated by Dr. Okinesye "The medical profession under the control of the conscience, is essentially a constant action of Justice, of Charity and of Prudence."

To digress for a moment, it might be well to consider the importance of a little mature reflection or a little deliberate calculation in contra-distinction to hasty responses or rash decisions, especially when the profession is being chastised. The former attitude will usually develop wise counsel, whereas the latter will result in attitudes to depreciate the entire medical profession, and no response at all and aloofness might have been the better course to follow.

At this point I might emphasize that prudence is quite essential in dealing with the affairs and activities of this Society, and that all the problems that arise should be equally shared with the various committees rather than to resort to individual and positive decisions that might involve the entire Society. Please be reminded that the qualities of prudence and wisdom are met with in the man of distinction.

Are we meeting our pledges and obligations? Yes, and a great deal more. Never in the history of man has he been privileged with available medical care on such a high plane, of such a competent nature, and of such magnitude. On the other hand, never has there been so much self-imposed voluntary study for improvement on the part of the medical profession.

At the turn of the century, the works of Jules Verne, the French scientific novelist, were being read avidly, such as 20 Thousand Leagues Under the Seas, Mysterious Island, Around the World in 80 Days, etc. These works were of ingenious mental inventions, lively, captivating, fantastic, as well as instructive and imaginative. At that time, the dreams of Jules Verne seemed more fantastic than practical, more whimsical than attainable. Had anyone subscribed to these illusory ramblings he certainly would have been branded as being gullible. What appeared to be scientific dreams of Jules Verne fifty years ago, now in retrospect make one respect his mental daring and imaginative inventions.

We can very well apply this line of thought to the prophecies that were made at that time concerning the future of medicine. During the past fifty years medicine has made unbelievable progress and has been projected by two very important stimuli, both of which came as a result of wars. Since World War II one cannot deny that there has been a vicious race in the promotion and development of electronics and atomic energy in both furthering warfare and industry, but the race also had had its effect in medicine where the progress is occurring at a vertiginous speed. Medicine has not lagged behind; to the contrary, revolutionary discoveries and intensive research in every field and phase of medicine are revealed almost daily.

The entire pattern of medical education has been improved, requirements have been increased and the curriculum is far more stringent than it was twenty-five, fifteen or even ten years ago. The objectives are quite apparent, namely, better preparation, better foundation and therefore better and more competent medical men to render better medical care.

Nowhere in any of the various phases of the medical profession is there any evidence that we are not meeting our pledges as a group. The premedical student of today has far greater burdensome studies than but a few years ago; the medical student likewise has a most difficult program; the professors in the medical schools have increasing

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A CASE REPORT AND COMMENT*

FRANCIS J. KING, M.D., F.A.C.S., FRANCIS P. VOSE, M.D., and PAUL COHEN, M.D.

The Authors. *Francis J. King, M.D., F.A.C.S., Chief of Surgery; Francis P. Vose, M.D., Medical Department, and Paul Cohen, M.D., Department of Anesthesia, Woonsocket Hospital.*

This seemed a very interesting case, so much so that we turned it over to a young able physician in Providence to see if he could keep up with the Woonsocket group. You can see by the discussion that he did not absolutely get it, but we consider it a most excellent discussion and a good example of what a clinical-pathological conference should be.

—THE EDITOR

THIS fifty-four-year-old male was admitted to the hospital at 10:20 P.M. on January 20, 1955.

C.C.: Excruciating epigastric pain and in shock.

Past History: Patient had had G.I. symptoms for a number of years very suggestive of a peptic ulcer. He had been out of work for six months and could not afford medical care or medication but he had been on a bland diet and had taken antacids occasionally. He was symptom-free up till the present episode. He had never had surgery, nor X rays.

Family History: Non-contributory. The patient lives at home with his wife. No children.

P.I.: This patient presented no symptoms whatsoever until he ate his supper consisting of a meat pie. Immediately after eating he felt as though he was too full and should burp. He took a walk outside and vomited once, most of the food that he had ingested. Immediately, he felt a severe pain in his epigastrium. On arrival home he vomited a small amount of brownish colored fluid. The pain became excruciating; it was referred to the back about the level of the lower thoracic vertebra. The patient was pale and sweaty. His wife called the family physician at 7:10 P.M. She was advised to give him a small amount of baking soda in warm water, which he promptly vomited. The doctor arrived about 9:20 P.M. The abdomen was board-like. He gave the patient a ¼ of morphia. It did not relieve him so he gave him another ⅛ 20 minutes later. As this did not relieve the pain he was sent to the hospital.

*Presented at a Clinical-Pathological Conference of the Woonsocket Hospital Staff, February 14, 1955.

On admission to the hospital he was immediately taken to X ray and an abdominal series done. A summary of the roentgen diagnosis follows:

1. Features of cardiac enlargement with decompensation, and arteriosclerosis of the aorta out of proportion to the patient's age.

2. Marked dilatation of the stomach, exact etiology must await upper G.I. series. The upper G.I. series should definitely be preceded by at least three to four days of Levein Tube drainage.

On admission to the ward, his temperature was 97. Pulse 100—regular. Respirations 32. Blood pressure 150/90. Red cell count 5.03. WBC. 23.2. Hemoglobin 96. Polys. 88. Serum Amalyase 32 units. He was moaning with pain. His respirations were short and rapid as though he was protecting his upper abdomen or lower chest. His extremities were slightly dusky and cold. His abdomen was board-like although the lower abdomen was not as hard as the upper. There were definite crepitant rales over the right base. His tongue was moist and clean. As he got no relief from the previous medication of morphia, the patient was given 100 mgs. of demerol at about 11:30 P.M. He was perspiring profusely with visible moisture on his forehead. An EKG was done which was normal. Very shortly after the demerol was administered, he showed a variety of central nervous system disturbances including nuchal rigidity, clonus, divergent gaze and carpopedal spasm. He was put into an oxygen tent. Color improved somewhat. His upper respiratory tract seemed to be somewhat blocked so an air-way was slipped in although patient seemed to be going into coma. The patient promptly expelled the air-way.

* * *

SUMMARY

This fifty-four-year-old male with excruciating epigastric pain referred to the midback with a temperature of 97, pulse 100, respirations 32, B.P. 150 90, white count of 23,000 and 88% polys, a normal EKG and crepitant rales in his right base, was desperately ill. The priest was called to administer the last rites.

* * *

The patient was kept in oxygen off and on during the night although he did not feel comfortable

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in the tent or with a mask. He was conscious at times and drank small amounts of fluid. I.V. therapy or blood transfusion was discussed and ruled against. The next morning the patient was able to talk. His respirations were short and grunting in character. He was definitely cyanotic at times. He had been given 5 grains of Sodium Luminal, Penicillin SRD 1 gram I.M. and Terramycin 100 mgs. I.M. every six hours. During the early morning hours his blood pressure dropped to 108 70. His pulse was 136. A repeat ECG was normal. He had morphia at 8:30 A.M. with some relief and again at 12:15. His Serum Amalyse in the morning had dropped 8. NPN 34. Creatinine 2.25. Sugar 183. C.B.C.—red count 4.91. White count 14.9. Hemoglobin 100. Polys 78. Sed. Rate 4 mm. Hematocrit 51 vpc. His temperature gradually climbed to 102.6. Respirations went up to 40. Pulse 136. The patient expired at 4:25 P.M. Permission for an autopsy was obtained.

* * *

Discussion

This fifty-four-year-old male lived less than twenty-four hours after hospital admission. Some of the diseases that might explain his excruciating epigastric pain and rapid downhill course are myocardial infarction, dissecting aneurysm of the aorta, mesenteric vascular occlusion, spontaneous rupture of the esophagus, perforated peptic ulcer, and acute pancreatitis.

The cardiac enlargement by X ray and the arteriosclerotic aorta suggest that he may have had some arteriosclerotic heart disease or that he may have been hypertensive, and the admission blood pressure of 150 90 may have been low for him. A blood sugar of 183 could have been due to his acute disease or he may have been a mild diabetic and thus more prone to premature arteriosclerosis. The normal EKG on admission and again several hours later would fairly well rule out an acute myocardial infarction severe enough to be fatal.

A dissecting aneurysm of the aorta could produce such a picture and the neurological signs could thus be due to interference with the blood supply to the central nervous system; but one would like to have either the appearance of an aortic diastolic murmur, if the dissection involves the aortic valves, or an inequality or disappearance of one or more pulses.

A mesenteric vascular occlusion would have to be considered, but seems unlikely as such a condition is more apt to occur in elderly patients, especially post-operatively, or as a complication of auricular fibrillation.

A spontaneous rupture of the esophagus is rare but could produce such a picture, the rupture being produced by extremely vigorous retching and vomiting. A ruptured esophagus is most commonly seen in a male alcoholic and the pain is usually retrosternal rather than epigastric, but often radiates to the back. However, following a rupture of the esophagus, subcutaneous emphysema and a left hydrothorax or hydropneumothorax almost invariably appear and a chest X ray may show air in the mediastinum. Possibly the arteriosclerosis of the aorta noted on chest X ray may have been mediastinitis, and a hydropneumothorax may not have developed until after the X ray was taken, and may have contributed to the patient's marked respiratory distress terminally.

A perforated peptic ulcer would certainly be suspected in this patient with an ulcer history. However, the absence of pain radiation to the right shoulder due to irritation of the diaphragm and the presumed absence of diminished liver dullness are factors against such a diagnosis. Also since an X ray of the abdomen taken in the upright position should show free air under the diaphragm in over two-thirds of patients with perforated ulcers, this diagnosis becomes even more untenable but certainly can't be ruled out.

Finally the sudden onset of excruciating epigastric pain with shock in a middle-aged male after a heavy meal always suggests acute pancreatitis. Acute pancreatitis occurs predominantly in patients suffering from alcoholism or gallstones of which there is no history here, or in patients with duodenal ulcers, or in normal persons after a heavy meal as may have been the case here. Hyperglycemia or glycosuria is found in about 40% of patients with acute pancreatitis and although there is no mention of a urinalysis, his blood sugar was 183. The hematocrit of 51 indicates some hemoconcentration which is often found in acute pancreatitis. Hypocalcemic tetany occurs in some patients with acute pancreatitis and might explain the carpopedal spasm and some of the neurologic findings mentioned. A flat plate of the abdomen usually shows paralytic ileus which might explain the markedly dilated stomach. The patient's rapid downhill course is also consistent with acute necrotic or hemorrhagic pancreatitis which is fatal in over 50% of cases. However, the most disturbing factor in such a diagnosis is the absence of a high serum amylase which in over 80% of patients with acute pancreatitis rises to levels over 250 Somogyi units.

In conclusion, a myocardial infarction, a dissecting aneurysm of the aorta, or a mesenteric vascular occlusion seem unlikely, leaving a ruptured esophagus, a perforated ulcer, and acute pancreatitis as possibilities. The absence of subcutaneous emphysema and the absence of air in the mediastinum and left chest cavity make a ruptured esophagus unlikely. The absence of free air in the peritoneal cavity makes a diagnosis of a ruptured ulcer rather dubious and a normal serum amylase

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MEDICINE'S PROCLAMATION OF FAITH*

ELMER HESS, M.D.

The Author, *Elmer Hess, M.D., of Erie, Pennsylvania, President of the American Medical Association.*

AS A MAN counts his years, he finds among them some that are indelibly marked by an event or experience of special significance. It is the sum total of these that give meaning to his existence. Although I am proud to claim this evening, I do so with the knowledge that it is not my own. It rightfully belongs to my colleagues who have contributed so much to American medicine and to the public good.

In taking office tonight as President of the American Medical Association, I am deeply aware of the grave responsibility that the medical profession has to the people of this nation. It is my fervent hope that we shall continue to be worthy of the faith and trust that our fellow citizens have placed in us, and I pray that I can make some small contribution to a better understanding of our mutual problems.

This country was born of faith in a future free of oppression, faith in the individual enterprise of man, faith in people, and faith in the Almighty. During the past year, as President-Elect of the Association, I have traveled many thousands of miles and have had an opportunity to observe at first hand the miracle that this faith has created in our land. It is apparent everywhere that our strength and our real wealth lie in the faith of our people, for whose health we are responsible.

Sometimes I feel that physicians have been too casual in seeking public understanding. We are so interested in our work that we often fail to take the public into our confidence. We must tell the public frankly what we are doing or we cannot hope to maintain the public's confidence. Not so long ago, a friend in my home town of Erie complained to me about her inability to get a doctor at night. I asked her if she had tried to get one through the Erie County Medical Society's emergency call service. She replied she had never heard of it. I knew that we had made every effort to acquaint the public with this service, but apparently it was not enough. My friend was amazed that she could get a doctor on short notice through this service.

Similar misunderstandings have arisen about the American Medical Association because we have failed to inform the public of our objectives in behalf of the American people. Most complaints brought to our attention are the result of failure to adequately explain medical costs. The relationship between physicians and their patients would be greatly improved if doctors would anticipate this question and discuss it frankly with their patients. I also think that much of our trouble comes from the fact that our medical schools have concentrated on the scientific aspects of medicine, which is all important to the public. However, the school should also emphasize the teaching of the humanities, which, after all, is treating your brother as you would be treated yourself.

We must be trained to take into the sickroom more than our scientific skill. We must allay fear, inspire confidence, and strengthen the patient's determination to get well. Unless we are willing to give of ourselves and our faith, our science will avail us little. Let me tell you of a personal experience that I believe was the best medicine I ever practiced. Several years ago I was called to care for an elderly lady who had an inoperable cancer. All we could do was make her as comfortable as possible. One morning she called me to her bedside at the hospital and asked if I would pray for her. I knelt by her bed and said the prayers while she made the responses. When I finished I ordered the nurses on each shift to take a few minutes to say prayers with the dying woman. To my amazement this sweet old lady, who lived for about six weeks, never again asked for sedatives to ease her pain. When I asked her about this one day, she replied, "Doctor Hess, I want my mind clear when these dear women pray with me."

Sometimes what we need most in the sickroom is not the medicine that we prescribe. It is the faith and the hope that we can instill in our patients. I don't care whether you are a Catholic, a Protestant, or a Jew just so long as you believe in a Power greater than all the instruments of science at your command. Faith is more than the acceptance of a creed, the practice of a religion, or the reading of a Bible. It is best expressed in that which we do

continued on next page

*Inaugural address delivered at the 104th Annual Meeting of the American Medical Association, at Atlantic City, New Jersey, June 7, 1955.

every waking moment of our lives without expectation of material reward. True faith cannot be built upon a foundation of complete selfishness.

I think one of the finest examples of this type of faith has been demonstrated by the behavior of the modest, young research physician at the University of Pittsburgh—Jonas Salk. The poliomyelitis vaccine that he developed could have made him a multimillionaire, but following the tradition of Pasteur, Jenner, Banting, Fleming, and all other great medical scientists, he has repeatedly spurned monetary reward for this great work. Dr. Salk gave the vaccine to the world. He did not seek to exact financial tribute for the countless hours he spent away from his home and his family in conducting his research. Thousands of physicians voluntarily contributed their time last year in the crucial tests to check the efficiency of the vaccine. Since the results of the tests were made known this year, private physicians have again given of their time and services to administer the vaccine to first and second grade school children, who have been designated as the most susceptible to poliomyelitis. I would like to appeal to the adult population at this time to stand aside and wait for our children to get the inoculations. The children must be given this protection first, and the physicians of the nation are pledged to see that no child is deprived of the vaccine.

Program

All that the medical profession has done and will do during the years ahead is based on selfless dedication to humanity. Through the American Medical Association, the nation's physicians are united in a vigorous program to improve the quality of care in our mental hospitals, to provide adequate hospitalization and medical care for the people who cannot afford to buy insurance against the eventuality of serious illness, to encourage the building of low-cost convalescent facilities for those who suffer from long-term illnesses, and to maintain the high standard of medical education while increasing the output of physicians and the building of more medical training facilities.

Mental illness cannot be cured by buildings alone. Too many of our institutions are little more than storage places where men and women suffering from disturbances of the mind are set aside indefinitely with little hope for cure. There is a crying need for more trained help, more research, and more interest on the part of state and county governments and the public in financing adequate care for these unfortunates. More than half of the nation's hospital beds are today occupied by mental patients. Properly treated, many of these people are salvageable. The situation is critical and cannot be ignored. The American Medical Association has pledged its combined resources to solve this problem.

We know that there are many people in this country who, because of low incomes or no incomes, are unable to buy hospital and medical care insurance. Many of these individuals are in the older age groups and live on small pensions. They are the responsibility of all citizens as taxpayers in their respective communities. We doctors must do all we can, through our local medical societies, to encourage the provision of adequate hospital care for these people in their home communities and continue our tradition of providing free medical care for those unable to pay. We need more nursing homes to care for the individuals who suffer from long-term illnesses. These are the people who need hospital beds but not the expensive, specialized attention that is given patients with an acute illness. Those who suffer from a chronic illness cannot afford regular hospitalization. We are solidly behind the efforts of the federal government to help local governments build nursing homes adjacent to our hospitals that would care for the chronically ill at a nominal cost.

Now, for a moment, let us look at medical education. While the population of the nation has approximately doubled since 1910, enrollment in approved schools of medicine has increased more than 125%—from 12,500 to 28,200 students. In 1910 there were only 3,165 physicians graduated from approved medical schools, as compared to 6,861 in 1954, an increase of 115%. Within the next five years there will be 10 new four-year medical schools in operation, bringing the nation's total to 90. This will increase the number of graduates from approved medical schools to about 7,500 each year. Physicians graduating from medical schools in the United States today not only exceed in number those graduated in the early part of this century, but they have infinitely superior medical knowledge because of the high standards of medical education that have been achieved. This improvement is due primarily to the frequently misunderstood efforts of the American Medical Association and the Association of American Medical Colleges to elevate the standards of instruction in our medical schools. We have never believed in sacrificing quality for quantity and we do not believe so today.

Strengthening Faith

I have enumerated but a few of the positive steps that the medical profession is taking to keep faith with our people. We solicit your continued faith and confidence in us. At the same time, there are other areas in which the American people must strengthen their faith. Faith in our present system of government is just as important as the faith we have in ourselves and in our God. In the past 179 years, other governments have survived; ours has achieved. We have grown and we are still growing. We have progressed and we are on the threshold of

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IMPROVED HEALTH FOR RHODE ISLANDERS

THE CONFERENCE on official health services in Rhode Island, conducted under the auspices of the Providence Council of Community Services, was an outstanding example of community action to consider the services and responsibilities of our varied health services in the interest of the public. The approximately 120 professional workers in health and welfare who accepted the Governor's invitation to meet and assess the development and financing of official health services throughout the state gave willingly of their time and talents. We hope the recommendations forthcoming from the individual work groups will get equally serious attention in the coming months.

Without singling out any proposals for priority, it is proper, we think, to report some of the major suggestions resolved by the workers in the specialty fields as the result of the round-table conferences. These are stated briefly as follows:

Only three communities are spending between one-two dollars per person, and some as low as two cents, for environmental sanitation; proper legislation is lacking to carry out effective sanitation measures. The health department should provide the exclusive services of a technician to inform communities of the available services and programs of the department, and all local communities should be encouraged to develop self-studies.

In the field of communicable disease there is a lack of nurses for home treatments of patients; there is need for the strengthening of local resources for spotting infectious diseases, and there is great need for control of insect infectors, water pollution, and for examination of food handlers. The lack of local community interest prevents adequate appropriations for some of these health needs.

Public health laboratory services should be centralized in the state laboratory. Local towns do not have the volume of work to warrant local laboratories, and collection agencies to deliver specimens in state cars to the central laboratory would be far more economical. Trained personnel is needed, and since Rhode Island is reported as forty-seventh in grade for salaries in the states to health workers, an increase in pay scales for personnel is warranted. Clinical and ancillary laboratories should be licensed by the state health department.

There is need for a full-time maternal health director at local levels to aid in detection, diagno-

continued on next page

sis and follow-up of maternal and child health illnesses. Child psychiatric services should be expanded.

The increasing attention to chronic diseases warrants a state-wide survey, possibly under the Hill-Burton bill provisions. But there should be a lessening of Federal funds, and a development of local responsibility to meet local health services. The state rehabilitation programs should be expanded, and local ones started. There should be better use made of the welfare department in-training program, particularly as it applies to nursing. A state-wide community health council might aid in resolving major issues.

Any health department to be really effective needs a good health education program with qualified personnel to direct it. The present state health education services should be expanded to aid local communities. Much statistical data is available, for example, morbidity figures developed by the temporary disability division of the department of employment security, but it is not used in public health education.

These suggestions and recommendations from persons closest to the tasks of guiding and carrying out health and welfare work in every community of Rhode Island, provide platforms for many progressive stages in building a better health for every citizen. The General Assembly has enacted the permissive legislation for the forming of local health units in three districts encompassing thirty-two towns. The need now is for local communities to band together and make the unit plan workable.

THE 144th ANNUAL MEETING

Alfred North Whitehead, the late British mathematician and philosopher, stated that the good American doctor is one of the most advanced types of human being on earth, because in him science is devoted to the relief of suffering. Some fifteen years later in the shadow of atomic and hydrogen explosions this view appears more valid than ever. The recent annual meeting of the Rhode Island Medical Society, founded one hundred forty-three years ago for the purpose of improving the quality of medical care in this community, exemplifies on the local scene the currency of this concept.

Several of the papers presented at these meetings surveyed progress in diagnostic and therapeutic measures in the various specialties. These included clinical reviews by Hayes Martin of New York, on the diagnostic significance of a lump in the neck; by Dale G. Friend of Boston, on the evaluation of new drugs; by Somers H. Sturgis of Boston, on hormone therapy and by William B. Bean of Iowa City, on the diagnostic value of the tongue in medical practice. The discussion on cryptorchidism by Charles Higgins of Cleveland was a résumé of the changing concepts in this field. The panel on "The Management of Children with Abdominal Pain" presented by Doctors Baty, Swenson and Berman of the Boston Floating Hospital was a model of its kind and suggests the desirability of repeating and expanding upon this type of presentation.

The essay by Dr. Herman A. Lawson on plasma protein abnormalities in myelomatosis is further evidence of the excellent investigative work in progress in our local hospitals. The report of Dwight E. Harken of Peter Bent Brigham Hospital on the striking results accomplished in the treatment of acquired aortic stenosis by the finger fracture method represents progress in the very vanguard of medical endeavor.

The Charles V. Chapin Medal was awarded to Dr. John F. Enders of the Harvard Medical School, Nobel Prize winner in Physiology and Medicine in 1954. His report on the culture of poliomyelitis virus, a highly news-worthy subject at this time, was perhaps the high spot of the meetings.

Dr. Henri E. Gauthier is to be congratulated on his efficient and intelligent administration, and on the high quality of the meetings which culminated his term of office. While we are about it, we should not forget to congratulate the distaff side for the highly successful conduct of its affairs, and pay particular tribute to the retiring president of the Women's Auxiliary, Mrs. Banice Feinberg.

NURSES NEEDED

The Rhode Island General Assembly at its recent session appropriated twelve thousand dollars as scholarship funds for state beneficiaries who may be trained as professional nurses, extended the time for the study commission to report on extending facilities for the training of practical nurses, and also considered the creation of a special survey commission to make a comprehensive study of the acute shortage of registered nurses, and medical and laboratory technicians.

No one will deny that there is a serious and growing need for more nurses throughout the country. Congressman Bolton of Ohio has a bill before Congress that provides for a National Commission on Nursing Services, set up along the lines of the Hoover Commission, to study the entire field of nursing, determine the causes for the present nursing situation, and make recommendations to Congress as to what should be done about the situation.

What the Rhode Island Assembly has done is a step in the right direction to meet the situation currently. But what is more important appears to be the establishment of a qualified group to make an analysis of the state nursing needs, and then to recommend what steps shall be taken. A state ap-

pointed commission is not necessary; the nursing associations themselves might well take the lead in setting up a citizens' study group that could report to the public as well as the legislature.

VACCINE NOT THE ANSWER

The nation thrilled at the news of the success of the Salk vaccine that promises to control polio. But the same rejoicing public continues its apathetic way when research on highway safety is presented and the grim statistics on the number of fatal accidents is reported annually.

In 1954 we are told that 35,500 persons were killed and 1,960,000 were injured on our highways.

Present the same statistics for polio, cancer, or any other disease to the public and it is aroused to contribute generously to funds for research, and is ready to listen to advice on the prevention and detection of the disease.

But there is no vaccine to be developed to remove highway accidents from the list of major killers and cripplers of human life. Major safety appliances for automobiles, and their passengers, may help, but to no great degree. The cure is in preventing the occurrence of accidents, and in the ceaseless education of every motorist to his responsibility to himself and his fellowman once he slides behind the wheel of one of our modern chariots and wheels at breakneck speed over super highways, or hurries his pace through our crowded thoroughfares.

In spite of the millions spent by state and community authorities to provide safer and better roads, and to encourage saner driving, the needless slaughter and the accompanying waste of human and property values continues. Who is at fault? We—the drivers of automobiles hold the answer to all the grim statistics that now make the family motor vacation a tense ride instead of a pleasant trip.

In addition to the figures cited above, consider the following statistics we motorists compiled in 1954, as compiled by the Travelers Insurance Company:

Our speeding on our streets and highways killed 12,380 and injured 659,000 men, women and children.

We saw 7,700 pedestrians killed in traffic accidents.

Our week-end crashes accounted for 13,980 killed and 678,000 hurt, with 39% of the deaths and 35% of the injuries occurring on Saturdays and Sundays.

We recorded 24% of all drivers in fatal auto accidents as being under twenty-five years of age.

And we accounted for three fourths of all this human damage to our fellowmen on dry roads in clear weather, with excessive speed as the principal cause.

The problem starts and ends with the driver. It is time that all of us stopped asking when science will find a cure for some of the so-called major diseases that afflict us, and instead gave some serious thought to preventing and curing the malady marked with the symptoms of recklessness and speed that afflicts too many motorists.

In the daily papers of May 19th one of our ablest physicians discusses the question of speeding ambulances. Only recently there was a serious accident as a result of the reckless driving of an ambulance. Several years ago the same kind of driving of an ambulance killed a judge and several of his family who had the right of way. The writer of this editorial was in a position to know that the patient being hurried to the hospital had been sick for a very long period and was simply being taken in for study. It is time that lovers of speed should be stopped from using the ambulance as an excuse for indulging their speed mania.

Any physician who has in his intern days ridden an ambulance knows that the occasions when it is necessary to drive such a vehicle with reckless speed are about as few and far between as hen's teeth. We see no reason why ambulances should be equipped with screeching sirens. The one vehicle that really needs to hurry is the fire apparatus. It is our impression that they are as carefully driven as anything that we see on the highways. They set a good example to the ambulances.

NEW MEDICINES AND NEW MEDICAL LITERATURE

We still think that Boston has good claims to be the cultural leader of the nation and from the literary viewpoint we have thought of the ATLANTIC MONTHLY as the leader of a matriarchy. To be sure, the buxom western girls might feel that she was a flat-chested old spinster, but they may change their minds if they read in the June ATLANTIC *Victory Over Polio*. She certainly has donned falsies. Listen to this brisk writing:

> "The crowds of reporters, newsreel men, TV cameras and photographers gathered at Ann Arbor created an atmosphere of excitement hitherto reserved for the World Series. . . . The American people must be growing up when we can find an important medical achievement as newsworthy as one in sports or war. . . . Assuming that the vaccine will reduce paralytic polio to the vanishing point. . . . The outcome emphasizes the fact that medical victories today are won by teams of researchers, not by the dedicated isolation of a Jenner or a Pasteur. . . . The National Foundation may turn to other fields of medical research. One which seems highly appropriate is the study of the crushing blow that the brain suffers when an artery is blocked or breaks."

We are sorry to discover, however, one weak note in their brave talk. In one place they say: "The search for a cure for the disease will continue." It would hardly seem worthwhile for an organization as big in spending power as the Na-

continued on next page

tional Foundation to be searching for a cure of a disease which has been reduced to the vanishing point.

In the same mail with this brilliant ATLANTIC writing, we received a copy of what Editor Weeks must feel is the stodgy old NEW ENGLAND JOURNAL OF MEDICINE. Here we read:

"The Editors of the JOURNAL, awed by the incandescent publicity accompanying the revelation that a vaccine of practical effectiveness against poliomyelitis may be at hand, have so far refrained from making any statement. . . . Any word of caution against . . . the thesis that poliomyelitis will shortly become a disease of the past would have been insignificant, unpopular and unheeded. . . . The difficulties of producing a vaccine effective against a virus infection are too well known . . . to be gone into here. . . . It becomes apparent that the situation requires a calm appraisal."

From Hippocrates down through William Harvey and Sydenham, medical writing has been more the type produced by the NEW ENGLAND JOURNAL than that indulged in by the ATLANTIC. We are still not convinced that that sort of writing should be discarded. Art is long, decision difficult.

CONDOLENCES

One morning recently great headlines splashed over the front pages "The Use of Cutter Laboratories Vaccine Stopped — A Number of Deaths Among Those Who Have Received Their Polio Vaccine." Now you may imagine that that was a pretty shocking thing to the Cutter Laboratories. They have been producing biological materials for over half a century anyway and these materials have been used all over our country if not all over the world. Great quantities of them have been used right here in our little state of Rhode Island. Also, these Laboratories have produced a great many vaccines in the past. If any one firm is well equipped for that sort of work, we would imagine that Cutter Laboratories are so equipped.

A few days ago we received what we feel is a pathetic letter from the president of the Cutter Laboratories who is a Doctor of Medicine. As he says, they have taken "a pasting." Some very nasty things have been said about them. We are writing this editorial; firstly, to express our confidence in this firm and; secondly, to deprecate the whole manner in which this vaccine production has been managed. It has been timed, not primarily for the careful handling of this very difficult problem, but primarily to produce a big sensation. We do not know, but we are suspicious that the hurry-up job and the interference of people who are not primarily scientists have made it especially difficult for the Cutter Laboratories and other firms to do their best work.

We think that the whole modern method of exploiting medical matters is fundamentally the difficulty with all this stuff. Things have to be done in a hurry. Every time doctors report on any new development, the papers of the next day and the magazines of the next month have long articles practically always highly optimistic showing that this new development is revolutionary and bound to eliminate disease and death. One might well wonder why there is any more bad sickness in the community as one sums up the enormous development of "life-saving drugs."

Then when something does go wrong, as it's bound to do in such a program, there has to be a scapegoat.

A few years ago, Parke, Davis & Company were producing one of the valuable antibiotics which they called chloromycetin. It was discovered that a number of deaths had occurred in people using chloromycetin. Immediately it was taken off the market and the world was informed that "Parke, Davis & Company had been putting out a murderous drug." We presume that it must have cost them millions, but what was worse was the great blow to their reputation for integrity. We know now that penicillin has probably caused many more deaths than chloromycetin. These powerful drugs which we are using nowadays are valuable. They save many lives but they are dangerous, and occasionally they cause a few deaths. Therefore, they should be used with more caution than they are. Particularly, the public should not be their own judges as to the use of these drugs. Our sympathy goes out to these firms who have suffered as a result of what we believe is the very poor modern method of exploiting whatever appeals to the sensation-loving minds of the public and their popular writers.

CREDIT IS OVERDUE

The excellent editorial in our May issue on "Looking Ahead in Mental Retardation" was a guest contribution to our editorial page, submitted at our request, by Doctor Charles Bradley, one-time superintendent of Bradley Home in East Providence, and now in charge of Oregon Psychiatric Services for Children as a member of the Oregon Medical School faculty. We apologize for failing in this instance to list the author of the editorial in the issue in which it appeared.

THE EDITOR

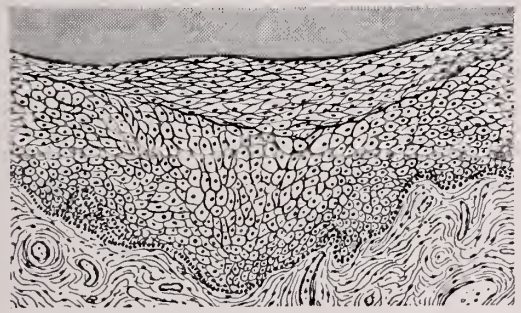
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Fellows may obtain single copies or full sets of the duplicate transactions of the Rhode Island Medical Society, 1859-1912, (unbound) at the Library.

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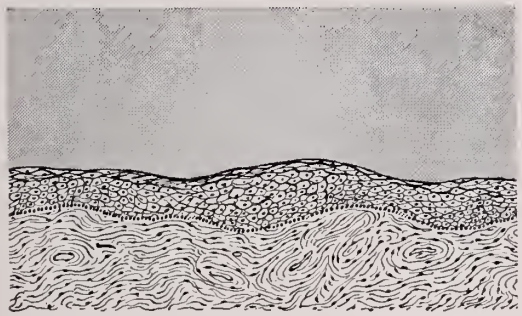
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*Sturnick, M. I., and Gargill, S. L.: New England J. Med. *247*:829 (Nov. 27) 1952.

SEARLE

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting held April 20, 1955

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library in Providence on Wednesday, April 20, 1955. The meeting was called to order by the President, Dr. Henri E. Gauthier, at 8:18 p.m.

The following were in attendance:

KENT COUNTY: Peter C. Erinakes, M.D., Edmund C. Hackman, M.D., Russell P. Hager, M.D. *PAWTUCKET DISTRICT:* James G. Chapman, M.D., Robert C. Hayes, M.D., Henry E. Turner, M.D., Harold A. Woodcome, M.D. *WASHINGTON COUNTY:* James A. McGrath, M.D. *PROVIDENCE MEDICAL ASSOCIATION:* Charles J. Ashworth, M.D., Robert R. Baldridge, M.D., Irving A. Beck, M.D., Wilfred I. Carney, M.D., Francis H. Chafee, M.D., William B. Cohen, M.D., John A. Dillon, M.D., Michael DiMaio, M.D., J. Merrill Gibson, M.D., John C. Ham, M.D., Hannibal Hamlin, M.D., Albert H. Jackvony, M.D., Ernest K. Landsteiner, M.D., William S. Nerone, M.D., Alfred L. Potter, M.D., Louis A. Sage, M.D., William J. Schwab, M.D., James J. Sheridan, M.D., George W. Waterman, M.D. *OFFICERS OF THE RIMS* (other than delegates): Henri E. Gauthier, M.D., John G. Walsh, M.D., Frank B. Cutts, M.D., Thomas Perry, Jr., M.D. *STATE HEALTH DEPARTMENT:* Director (without vote), Edward A. McLaughlin, M.D. *IMMEDIATE PAST PRESIDENT OF RHODE ISLAND MEDICAL SOCIETY* (without vote): Earl F. Kelly, M.D.

REPORT OF THE SECRETARY

Dr. Thomas Perry, Jr., Secretary, read his report, a copy of which was submitted to each member of the House and is made part of the official minutes of the meeting.

ACTION

It was moved that the report of the Secretary be received and placed on file.

RECOMMENDATIONS TO THE HOUSE

The Secretary presented the following recommendations from the Council of the Rhode Island Medical Society:

1. That the House of Delegates go on record requesting that, effective in 1956, the American Medical Association bill its membership in Rhode Island directly from its office in Chicago, such billing to be based on a certified list of members in good standing of the Rhode Island Medical Society.

ACTION

It was moved that the House approve of the recommendation. The motion was seconded and adopted.

2. That a slate of nominees for officers and standing committees of the Society, to serve from the annual meeting in 1955 until the annual meeting in 1956, be submitted with the approval of the Council.

ACTION

It was moved that the slate of officers and standing committees as submitted by the Council be approved and the members to be declared elected to the offices listed. The motion was seconded and adopted. (A copy of the slate of nominees is made part of the official records of the meeting.)

The Secretary reported the following recommendation from the Executive Committee of the Providence Medical Association:

3. That the House of Delegates review the entire problem of physician advertising, with particular reference to office display signs, telephone and other directory listings, newspaper displays, etc.

ACTION

It was moved that the problem presented by the Providence Medical Association be referred to the Society's Committee on Public Policy and Relations to report with recommendations to the House of Delegates at its September meeting in 1955. The motion was seconded and adopted.

ANNUAL REPORT OF THE TREASURER

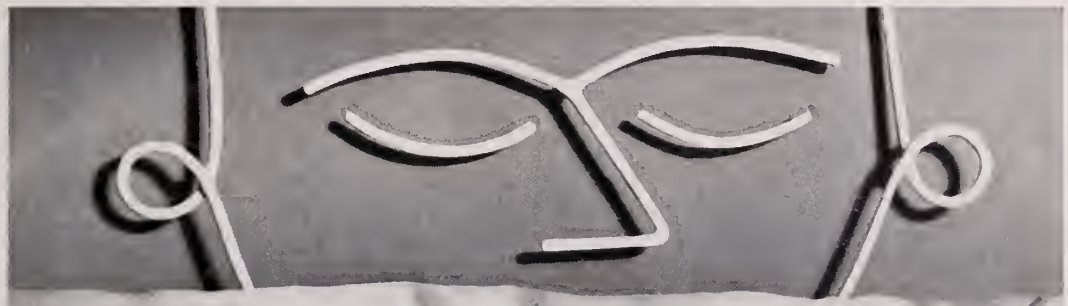
Dr. John A. Dillon, Treasurer, submitted to each member of the House a summary of the financial statement of the Society for the fiscal year 1954, which he reported had been reviewed and approved by the Council and the Society's elected auditors.

ACTION

It was moved that the Annual Report of the Treasurer be received and placed on file. The motion was seconded and adopted. (A copy of this report is made part of the official minutes of the meeting.)

continued on page 338

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In most cases—

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Scored 0.25- and 0.5-Gm. tablets.

C I B A Summit, N. J.

2/2075M

HOUSE OF DELEGATES

continued from page 336

REPORT OF THE BOARD OF TRUSTEES

Dr. John G. Walsh, Chairman of the Board of Trustees, submitted a written report, a copy of which had been sent to each delegate and copy of which is also made a part of the official minutes of this meeting.

ACTION

It was moved that the Report of the Board of Trustees be received and placed on file. The motion was seconded and adopted.

* * *

The Executive Secretary reported that one of the members of the Society, Dr. Stanley S. Freedman, was making a gift of a new lectern for the auditorium stage. The House voted that the Secretary should be instructed to convey its appreciation to Dr. Freedman for his gift.

COMMITTEE ON MEDICAL DEFENSE AND GRIEVANCE

In the absence of Dr. Francis B. Sargent, Chairman of the Committee on Medical Defense and Grievance, the Secretary presented his report, a copy of which had been sent to each delegate and copy of which is made part of the official minutes of the meeting.

Discussion: The report was briefly discussed and the House voted to amend *section b* in the first part of the report.

ACTION

It was moved that the report as amended be approved and placed on file. The motion was seconded and adopted.

* * *

The House moved that the Secretary in a letter to the membership incorporate the report of the Grievance Committee submitted to the House and as amended by it. The motion was seconded and adopted.

* * *

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The Secretary also read an Annual Report submitted by the Chairman of the Grievance Committee for possible publication in the RHODE ISLAND MEDICAL JOURNAL.

ACTION

It was voted that if the Publications Committee feels that the publication of the report is warranted in the RHODE ISLAND MEDICAL JOURNAL that only the first paragraph of it should be published. The motion was seconded and adopted.

CANCER COMMITTEE

Dr. George W. Waterman, Chairman of the Cancer Committee, discussed his report which had been sent to the delegates, and copy of which is made part of the official minutes of the meeting.

ACTION

It was moved that the report of the Cancer Committee be received and placed on file. The motion was seconded and adopted.

* * *

The motion was made that the recommendation of the Cancer Committee relative to the promotion of the knowledge of cancer through local district society meetings be approved, and the district societies be asked to cooperate with the Cancer Committee by assigning one meeting, annually, for such a program. The motion was seconded and adopted.

DIABETES COMMITTEE

In the absence of Dr. Louis Kramer, Chairman of the Diabetes Committee, the Secretary presented his report, copy of which had been sent to each delegate and copy of which is made part of the official minutes of this meeting.

ACTION

It was moved that the report of the Committee on Diabetes be received and placed on file. The motion was seconded and adopted.

DISASTER COMMITTEE

Dr. J. Merrill Gibson, Chairman of the Disaster Committee, gave an oral report on the Civil Defense Conference held in New York for discussion on protection against atomic warfare. He explained in detail some of the problems to be faced, including the question of mass evacuation of populations from metropolitan areas with the resulting problem of medical care for these people when moved to rural areas. He also briefly reported on the plans for Rhode Island including the mass evacuation test scheduled for June 15, 1955.

ACTION

It was moved that the report as presented be approved. The motion was seconded and adopted.

continued on page 340

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Thiamine mononitrate	10 mg.	Vitamin B_{12} activity	4 mcg.
Riboflavin	10 mg.	Folic acid	1.5 mg.
Niacinamide	100 mg.	Menadione (vitamin K analog)	2 mg.
Pyridoxine hydrochloride	2 mg.		

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HOUSE OF DELEGATES

continued from page 338

COMMITTEE ON PROFESSIONAL RELATIONS AND HOSPITALS

Dr. Charles J. Ashworth, Chairman of the Committee on Professional Relations and Hospitals, reported on the formation of the Rhode Island Joint Commission for the Improvement of the Care of the Patient. He discussed the development of this Commission and he reported that Dr. Arthur E. Hardy, one of the Society's representatives, had been elected as Vice-Chairman of the Commission.

He read the Administrative Regulations proposed for the Commission.

ACTION

It was moved that the report be received as presented. The motion was seconded and adopted.

* * *

It was moved that the Administrative Regulations for the Rhode Island Joint Commission for the improvement of the care of the patient be approved by the House of Delegates. The motion was seconded and adopted. (A copy of the above-mentioned rules are made part of the official minutes of the meeting.)

COMMITTEE ON PUBLIC LAWS

In the absence of Dr. James H. Fagan, Chairman of the Committee on Public Laws, the Executive Secretary reported briefly on major health and medical legislation before the General Assembly. He reviewed the action taken by the Committee on Public Laws to date on some of the proposals and he stated that a final report of the Committee could not be made until the final adjournment of the General Assembly.

PHYSICIANS SERVICE

Dr. Charles J. Ashworth, President of the Rhode Island Medical Society Physicians Service, reported on the following matters:

The position of Physicians Service relative to psychiatric care for the acute phases of mental illness: He reviewed the entire history of the coverage for mental illness under Physicians Service since the inauguration of the program and he read a report from the Claims Committee and a decision of the Board of Directors on the matter. He reported that the Board of Directors of Physicians Service had considered the action of the Claims Committee in resolving that a maximum of fifteen (15) days' coverage should be allowed for initial acute phases of mental illness to be one with which it is in full accord, and which it approves as a continuing policy under the current Physicians Service contract.

He also reported that the Board of Directors had also moved that the Executive Committee of Physicians Service be authorized to answer the communications from the Providence Medical Association and the Mental Health Committee of the Rhode Island Medical Society, and that it also inform the House of Delegates of the action of the Board of Directors, and further, that a copy of this communication be sent to each member of the Board of Directors.

He reported that Dr. G. Edward Crane had been elected by the Board to fill the unexpired term of the late Dr. Joseph C. O'Connell. He reported that a plan had been adopted by the directors to provide for a Liaison Committee in each district society with the administrative officers of Physicians Service. He reported on studies under way for the possible inclusion of x-ray benefits and for a possible new contract for a major industry with plants in Rhode Island.

ACTION

It was moved that the report presented by Dr. Ashworth be approved. The motion was seconded and adopted.

DISTRIBUTION OF POLIO VACCINE

Dr. Edward A. McLaughlin, State Director of Health, discussed the problem of polio vaccine distribution in Rhode Island. He stated that the manufacturers are presently faced with delays in meeting orders for the vaccine. Each available shipment at this time is released on authorization of order from the Infantile Paralysis Foundation and efforts are being made to take care of the southern states in view of the early school closing there and the start of the polio season earlier than in the northern areas. He stated that the first and second grades in the schools have received the vaccine free through the Paralysis Foundation grant. He discussed proposals of the state to purchase and make available the vaccine.

The proposal was discussed by the members of the House of Delegates.

ACTION

It was moved that the Society's Committee on

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CLINICAL DATA ON REQUEST

*Combes, F. C. & Canizares, O.: New York St. J. Med. 52:706, 1952; Marsh, W. C.: U. S. Armed Forces M. J. 1:1045, 1950.

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HOUSE OF DELEGATES

continued from page 340

Child and School Health be named to work with Dr. McLaughlin in establishing a plan of allocation of the polio vaccine in Rhode Island. The motion was seconded and adopted.

* * *

It was moved that the polio vaccine be provided free of charge only to those who are welfare patients or otherwise medically indigent. The motion was seconded and adopted.

1956 ANNUAL MEETING

Dr. Henri E. Gauthier, as Chairman of the Arrangements Committee for the 1956 Annual Meeting of the Society, suggested that the Rhode Island Academy of General Practice meet at the same time of the Society's Annual Meeting and be incorporated as a part of it. Dr. Peter Erinakes, an official of the Rhode Island Academy, was requested to submit the suggestion to that organization.

LECTURE BY MR. ROBERT VOGELER

The President reported that Mr. Robert Vogeler, who was a captive of the communists while working for the International Bell Telephone Company in Europe, would come to Providence on Wednesday, May 25, 1955, under the auspices of the Chas. Pfizer Company, to address the physicians on his personal experiences as a hostage of the communists. Dr. Gauthier reported that Mr. Vogeler has addressed medical meetings in many large American cities.

He suggested that the Rhode Island Medical Society co-sponsor the appearance of Mr. Vogeler with the Pfizer Company.

ACTION

It was moved that the Society accept the invitation to hear Mr. Vogeler and that it co-sponsor the meeting at the Narragansett Hotel. The motion was seconded and adopted.

ADJOURNMENT

Dr. Gauthier noted that this meeting of the House of Delegates concluded his service as presiding officer of the House, and he expressed his appreciation for the loyal and generous support given him throughout the year by the members in transacting the affairs of the Society.

The meeting adjourned at 10:45 P.M.

Respectfully submitted,

THOMAS PERRY, JR., M.D., *Secretary*

REPORT OF THE SECRETARY

To the House of Delegates:

The Council has held two meetings since the last session of the House of Delegates. Among the matters resolved by the Council were the following:

1. Approval was given actions of the President whereby he—

Referred to the Committee on Child Health Relations a request from the Parents Council for Retarded Children of Rhode Island for a meeting to discuss problems of that organization.

Accepted for the Society an invitation for himself and the Executive Secretary to serve as members of a New England local arrangements committee for the Interim Meeting of the American Medical Association to be held in Boston in December, 1955. The Council also authorized the President to pledge the Society's proportionate share toward the expense to be incurred by the medical societies of New England for a dinner for the delegates of the American Medical Association.

Issued a statement during National Nurse Week supporting the efforts of the Rhode Island State Nurses' Association to focus attention on the needs of nursing and nursing education.

Arranged for meetings between the Society's Committee on Industrial Health and the new State Workmen's Compensation Commission.

Arranged for a meeting of officers and other representatives of the Society with Dr. Frank Wilson, Director of the Washington Office of the American Medical Association, to discuss national health legislation.

Wrote a letter to the Fellows of the Society explaining in detail the reason for the increase in the annual assessment of dues.

2. The Council notified the Amalgamated Meat Cutters and Butcher Workmen of North America of the interest of the Society in the campaign to secure effective poultry regulation and inspection.

3. It authorized the President to name a representative to attend the annual meeting of the American Medical Education Foundation.

4. It authorized the President to notify the Governor of the State of Rhode Island of the Council's attitudes relative to a regional compact of higher education, particularly noting that a survey of the needs of the state should be first undertaken before legislative commitment is made.

5. It authorized the Executive Secretary to represent the Society at a meeting of the Medical Exhibitors Association in New York.

6. It voted to renew the Society's membership in the National Conference of Presidents and Other Officers of State Medical Associations.

7. It authorized the President to appoint two members of the Cancer Committee to represent the Society, and it further authorized these two mem-

bers to initiate for the Society the establishment of a proposed Advisory Coordinating Committee for Rhode Island to effect better organization in cancer education and control.

8. It authorized the Secretary to represent the Society at a community meeting to be called to discuss the formation of a United Fund as a solution to the present problem of multiple charitable campaigns.

9. It approved of a recommendation by the Treasurer to transfer the cash reserve of the Frank L. Day Fund to the general account of the Society, but crediting it to the Day Fund. This action will eliminate a separate check book, and deposit record for the Day Fund, and will place it within the pattern adopted for all the other special accounts of the Society.

The Council also approved of recommendations from the trust department of the Industrial National Bank relative to changes in some of the investments in the general account administered for the Society by the bank.

10. It approved of a report from the Committee on Professional Relations and Hospitals to be submitted to the House of Delegates.

11. It authorized the President and the Chairman of the Committee on Veterans Affairs to secure, if possible, a delegate to represent the Society at the meeting called by the American Medical Association to be held in February, 1955. It also voted that the Committee on Veterans Affairs explore the possibility of a meeting with leaders of veterans' organizations in Rhode Island to discuss problems relating to the medical care of veterans.

12. It authorized the Trustees of the Medical Library Building to proceed with necessary repairs to the building resulting in the main from hurricane damage.

13. It voted that members in their first year of practice shall be assessed half of the annual dues if elected to membership after June 30, and shall be subject to the full assessment effective January 1 of the ensuing year.

14. It voted that members resuming private practice after a tour of military service shall be exempt from the payment of dues for six months of the year in which they resume private practice.

15. It voted that the Interim Meeting of the Society for 1955 be held on Wednesday, October 26th, at a time and place to be decided by the Committee on Scientific Work and Annual Meeting.

Respectfully submitted,

THOMAS PERRY, JR., M.D., *Secretary*

continued on next page

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ANNUAL REPORT OF THE TREASURER RHODE ISLAND MEDICAL SOCIETY

Financial Report, 1954

SUMMARY

Cash balance, Checking Account, Industrial National Bank, January 1, 1954	$ 2,240.83
Receipts, 1954 (Exhibit A)	40,136.76
Total	$42,377.59
Expenses, 1954 (Exhibit B)	39,515.60
Cash balance, Checking Account, Industrial National Bank, January 1, 1955	$ 2,861.99
Cash balance, Checking Account, credited to Special Funds of the Society, January 1, 1955	622.65
Cash balance, Checking Account, Industrial National Bank, for Operating Expenses, January 1, 1955	2,239.34

* * *

Total Cash and Invested Assets, January 1, 1955:	
Cash balance, checking account, Industrial National Bank	2,861.99
Investments, Pooled Funds, Trust Department, Industrial National Bank Agent	
Total book value	32,099.92
Cash balance to be invested	1,831.87
Total	$36,793.78

JOHN A. DILLON, M.D., *Treasurer*

REPORT OF THE BOARD OF TRUSTEES OF THE MEDICAL LIBRARY

With the approval of the Council the Board of Trustees of the Rhode Island Medical Society Library have contracted for many needed repairs to the building.

To date the roof has been repaired where damaged by the hurricanes of 1954. Currently under contract is the insulation of the building exterior walls against water damage through a process of silicote spray on all the brickwork.

The auditorium has been repainted, a chair rail installed, and the floor thoroughly cleaned and waxed. The screen used for the projection of lantern slides has been attached above the stage platform, thus eliminating the unwieldy pipe frame supports previously used for the mounting of this screen. Drapes have been ordered for the auditorium windows, and estimates are being secured at this time for repairs to some of our oil paintings, and repainting of the picture frames.

The reading room has been repaired where needed, and repainted.

The cost for these repairs represents a sizable

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BOARD OF TRUSTEES

continued from page 344

outlay of the Society's funds, and it is to be regretted that long delay in making some of the necessary repairs to the building have only added to the repair cost. The heritage of our fine library is not to be taken lightly, and with the responsibility of having such an outstanding headquarters for the Rhode Island Medical Society goes the obligation to maintain it in proper condition.

Many additional repairs warrant consideration, and they will be brought to the attention of the Council in the coming months.

Respectfully submitted,

JOHN G. WALSH, M.D., *Chairman*

CANCER COMMITTEE

To the House of Delegates:

On behalf of the Cancer Committee, as Chairman of the Committee, I should like to make the following report:

The first of the report is in regard to the Annual Cancer Conference. For the last seven years we have had an annual conference at which we have had a good roster of speakers with a primary purpose of bringing to the members the latest on early signs and treatment of cancer. These meetings have been well attended and up to the last year were considered very successful. Owing to a multiplicity of meetings and possibly to the fact that the conference idea had somewhat worn off, the meeting last fall was not successful. The attendance was not up to standard.

Your committee, therefore, in considering the plans for the coming year, felt that the meeting this fall perhaps better be held over to next spring, there being many meetings in the fall and especially the meeting of the American Medical Association in Boston with treatment of cancer being discussed for anyone interested.

The Committee would like the House of Delegates to consider whether we should continue the Cancer Conference, or whether we should not have a meeting perhaps for a year or two, but promote the insemination of knowledge of cancer more through the local county societies. There are many fine movies available particularly through the American Cancer Society and its Rhode Island branch. Perhaps it might be well to try this idea having each society devote one meeting this year to such a plan. If the delegates see fit, your committee would like to have a resolution approving this idea of a yearly meeting devoted to early signs and treatment of cancer by the county societies.

The second item on this report is the formation of a "Cancer Coordinating Committee." At a meeting last fall the Cancer Committee initiated the idea

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Tetracyn-SF
Oral Suspension
2 oz.
Sig: 2 teaspoonfuls,
q.i.d.

The minimum daily dose of each antibiotic *(1 Gm. of Terramycin or Tetracyn, or 600,000 units of penicillin)*
Stress Fortifies the patient *with the stress vitamin formula* **recommended by the National Research Council:**

Ascorbic acid, U.S.P.	300 mg.	Calcium pantothenate	20 mg.
Thiamine mononitrate	10 mg.	Vitamin B_{12} activity	4 mcg.
Riboflavin	10 mg.	Folic acid	1.5 mg.
Niacinamide	100 mg.	Menadione (vitamin K analog)	2 mg.
Pyridoxine hydrochloride	2 mg.		

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CANCER COMMITTEE

continued from page 346

of having a coordinating committee of all the agencies of the state having to do with the cancer problem. A meeting was held with representatives of all the various organizations on January 12, 1955. The ground was very thoroughly explored and plans for future talks and integration of the programs were made. Another meeting of the Committee will be held some time this spring.

Very truly yours,

GEORGE W. WATERMAN, M.D., *Chairman*

REPORT OF COMMITTEE ON DIABETES

The Diabetes Detection Drive was held the week of November 14 to the 20, 1954. 11,080 urine tests were done throughout the State. A breakdown of these are as follows:

Private physicians 1,563; Providence and Newport Diabetes Fairs 211; Hospital 35; Industrial Clinics 3,129; Schools 4,169; Rhode Island Pharmaceutical Association 1,774; Private Laboratories 24; District Nurses 175.

Of the 11,080 urines checked, 136 were reported as positive. All were referred to their private physicians, and the last report was that 34 new diabetics were diagnosed. Blood sugar tests were done by the Clinitron method at the Diabetes Fairs. In Providence, 495 tests were taken; 35 were positive. In Newport, under the direction of Dr. Edward Zamil, 271 tests were taken and 33 were positive. Out of the 68 positive findings, 32 were known diabetics, and 48 new cases were discovered.

Of the 4,169 urines checked in the schools, three new cases were discovered. Out of the remaining 6,911 urines checked in industrial plants, etc., 133 were positive. It is not known at present how many of these were known diabetics.

We received Clinitest and Galatest, 10,000 of each, free of charge; 5,000 of each were used and the remainder will be returned. 21,000 St. Louis Dreypak were distributed and 9,071 were returned and processed by Mr. William Hagan of the Rhode Island Department of Health.

Both Providence and Newport had a Diabetes Fair. This Fair was held one day. Members of the Committee on Diabetes were present. Free blood and urine tests were done; there were movies on Diabetes, with question and answer periods; meal planning instructions, and several other exhibits were presented. We are very grateful to Mr. W. Connell for permitting us to use the offices of the Department of Employment Security for our Diabetes Fair. Participants in the Drive were: Rhode Island Medical Society, Auxiliary of the Rhode Island Medical Society, Rhode Island Dietetic Association, Nutrition Council of Rhode Island, Association of Clinical Laboratories, Rhode Island Restaurant Association, Rhode Island Department of Education, Rhode Island Chiropody Association, Rhode Island Pharmaceutical Association, Rhode Island League of Nursing Education, Rhode Island State Organization for Public Health Nursing, Rhode Island Social Workers, from the Rhode Island Department of Health: Industrial Nurses, Public Health Nurses, Laboratory Aid Health Education, Nutrition Service, Adult Heart Disease Control. Publicity was handled by local newspapers, radio stations, and television stations.

There will be a later report with a complete list of all participants.

Respectfully submitted,

LOUIS I. KRAMER, M.D., *Chairman*

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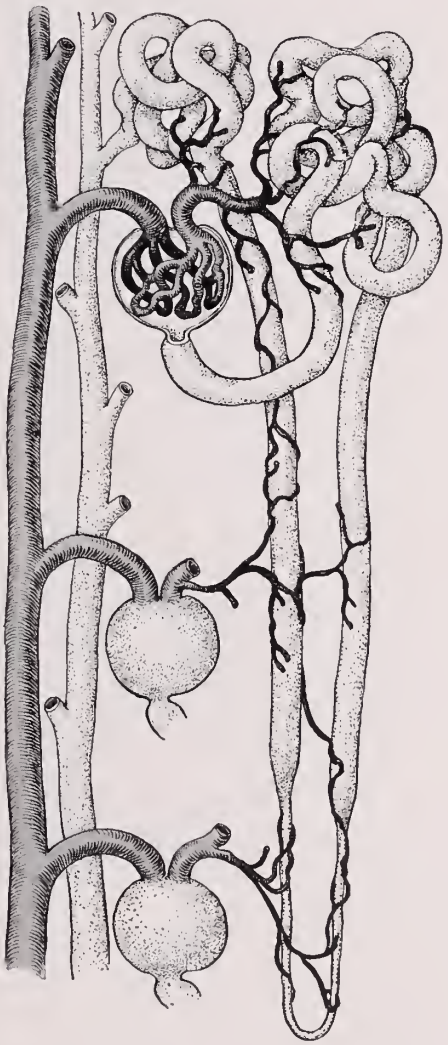
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MEETING OUR PLEDGES

concluded from page 326

knowledge to impart to their students; the state-board examinations of today are more rigid; for the recent medical graduates, the internship and the residency are more exacting and their many responsibilities weigh heavily and cause them to assume a rather scrupulous attitude in fulfilling their obligations; and finally, the practice of medicine, ever more specialized, is attendant with an infinitely increasing number of meetings.

In the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION for February 28, 1953, the following paragraph appears relevant to postgraduate medical education: "It is evident that it is not only desirable but absolutely essential for the physician to continue his medical education throughout his career if he is to carry out the responsibilities implicit in his license to practice. Since the public has seen fit to allow the profession to control its own affairs, it is the responsibility of organized medicine to insure the constant continuing education of its members."

Was it not Plato who said, "Education is a life-long business."

Truly, as stated by Ogilvie, "The physician plays a dual role—as servant of the public and as a scientific man. He cannot default in either capacity without injury to the other and without danger to the honorable fame of his calling."

And why are we so sincere in imposing so many meetings and obligations upon ourselves? The answer is quite evident. Our sole intent is to meet progress, meet our pledges and in so doing, continually strive to reach our ideals, namely, preserve our way of life, preserve our system of free enterprise and foremost, provide for the public the very best medical care.

In summary, we should all be proud to be members of such a noble profession, of such a dedicated profession, entirely governed by a self-imposed honor system, subdivided into groups of medical men dedicated to teaching, to practice in all of its phases, to prevention, and to research solely for the benefit of mankind.

A CASE REPORT AND COMMENT

concluded from page 328

is a strong point against acute pancreatitis. Nonetheless, acute necrotic or hemorrhagic pancreatitis seems the best bet.

* * *

Autopsy

On opening the thoracic cage, about 1 gallon of dark brownish black muddy liquid material was found occupying both pleural spaces and the anterior mediastinum. Both lungs were completely involved with a uniform hemorrhagic influenzal type of pneumonia. The pericardial cavity contained about 20 cc. of muddy brown odorless fluid containing specks of fibrin. There was a rupture of the lower one-third of the esophagus anterolaterally and on the left, readily admitting the index finger. The tissue surrounding this area of rupture was almost black in color, soft and friable. H. Influenza was cultured from the lungs and from the pericardial sac.

* * *

Comment by Doctor King

There is an excellent article in the February issue of the AMERICAN JOURNAL OF THE MEDICAL SCIENCES by Charles K. Kirby on "*Spontaneous*" *Rupture of the Esophagus.*

Dr. Kirby emphasizes subcutaneous emphysema in the supra-sternal notch or either supra-clavicular fossa and hydrothorax or hydropneumothorax. The former was not present in the above case, and the latter was not present four hours after perforation when the X rays were taken.

This man was not an alcoholic and had not eaten a large meal.

We believe the influenzal pneumonia led to perforation of the esophagus.

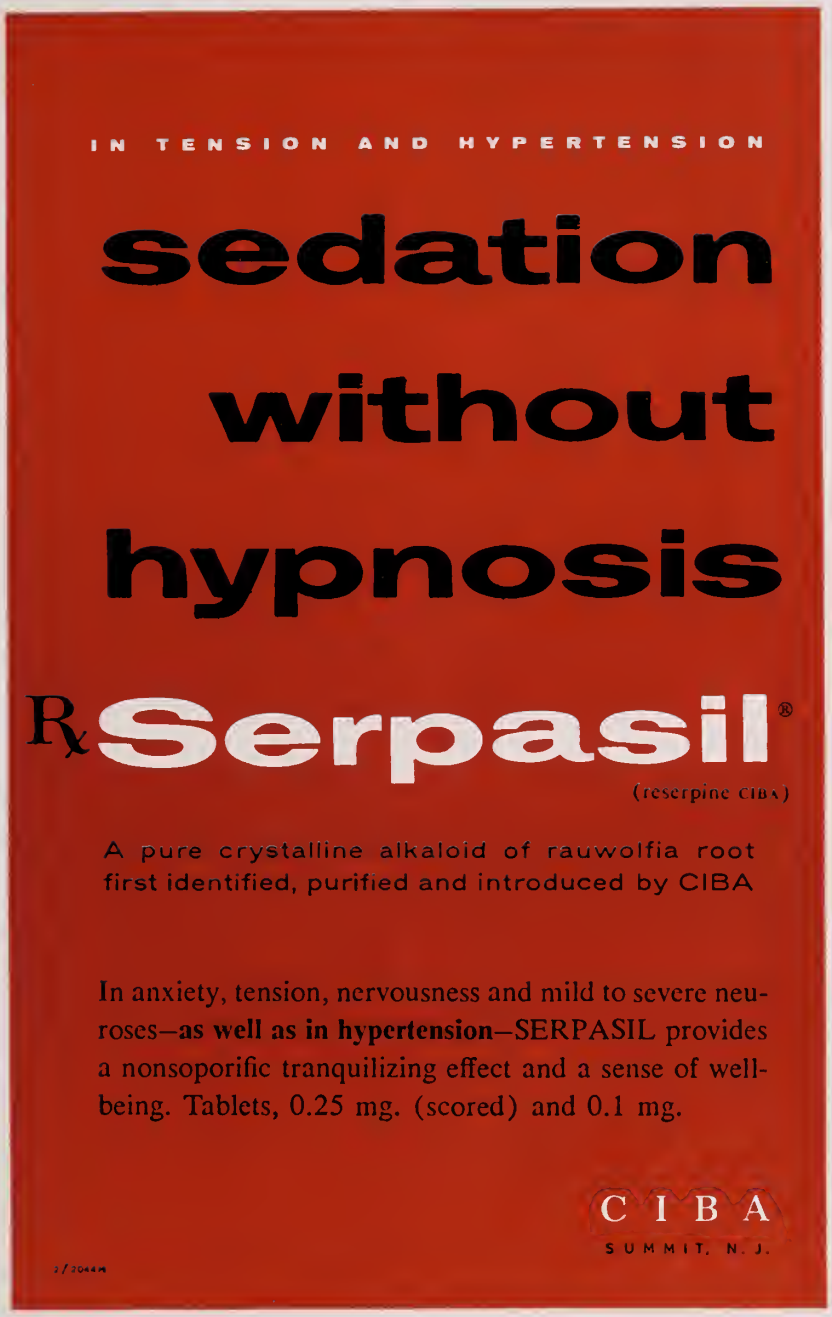
MEDICINE'S PROCLAMATION OF FAITH

concluded from page 330

even greater progress. We will never be perfect, but we are a vigorous nation, inhabited by a people gifted with initiative, imagination, and ingenuity. We must, as a people, cherish these attributes and strengthen our faith in their ability to keep our nation free. So long as we devoutly believe in the fatherhood of God and the brotherhood of man, it will be impossible to destroy America.

Faith is something bigger than we are. It is belief—belief in a Creator—if you wish, belief in God. During World War I, I served in the old Second Division. I never saw an atheist on the battlefield. The toughest prayed and swore, and even at times their profanity was a prayer. I have seen Jewish rabbis learn Protestant and Catholic prayers to aid those who were dying and Protestant and Catholic chaplains who learned the prayers of other faiths for the same reason. I have even helped a little myself in this direction when the chaplains were not around.

Yes, I'm convinced that the doctor has to be a man with firm convictions concerning a Creator and be fearless in the proclamation of his faith. I care not for his creed; I care not for his race—I care much for his belief and his demonstration of that belief by his loving, tender kindness when he is called upon to alleviate human suffering.



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DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was called to order by Dr. Robert Bestoso, President, at 8:30 p.m. on March 30, 1955, at the Hotel Viking with 18 members attending.

The speaker of the evening was Mr. Eddy of the Claims Division of the R. I. Physicians Service and Blue Cross.

Mr. Eddy spoke on the various problems of the Blue Cross, particularly concerning the patient's length of stay in the hospital, the benefit changes in the Plan during the past year, and various other modifications in the Plan; viz. the elimination of payment for blood transfusions and the non-payment for dental and obstetrical anesthesia. He mentioned that the Physicians Service Plan was of the lowest cost of any plan in the country.

At this time ensued a lively period of questions and answers.

The reading of the minutes of the previous meeting were dispensed with due to the lateness of the hour.

A motion was made by Dr. MacLeod that the members of the Society approve the Polio Vaccine Program and cooperate in the administration of the vaccine. This motion was seconded by Dr. Malone and passed.

The meeting adjourned at 11:15 p.m.

Respectfully submitted,

José M. Ramos, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, April 4, 1955. The meeting was called to order by the President, Francis H. Chafee, M.D., at 8:30 P.M.

The Secretary reported that all members of the Association are invited to attend a closed circuit television program on poliomyelitis which will be presented from 5:00 to 6:00 p.m. on Tuesday, April 12, 1955 at the Veterans Memorial Auditorium. The Secretary also reported that members of the Association are invited to a lecture at the Veterans Hospital on April 20, 1955 to be given by Doctor Robert Linton of Boston

Report of the Executive Committee: The Secretary reported for the Executive Committee as follows: At a recent meeting the Executive Committee approved of the plans of the Entertainment Committee to hold the Association's Annual Dinner and Golf Tournament at the Pawtucket Country Club on Wednesday, June 15, 1955.

The Executive Committee has voted to request that the House of Delegates of the Rhode Island Medical Society conduct an investigation of the entire problem of advertising by physicians with particular reference to listings in telephone and other directories, office sign listings, newspaper displays and so forth.

Report of the President: Doctor Chafee reported that testimonial tributes to deceased members of the Association have been filed with the Secretary for permanent records of the Association as follows: To the late Doctor J. Joseph Hoey by Doctors John G. Walsh and Ira Noyes; to the late Doctor Frank J. Jacobson by Doctors Harold Calder and Stanley Freedman; to the late Doctor Constant Schradieck by Doctors James H. Prior and Jack Savran. He also announced the appointment of a committee consisting of Doctors Halsey DeWolf and Herbert G. Partridge to prepare the Association's tribute to the late Doctor George L. Shattuck.

Presentation of Membership Certificates: The President awarded membership certificates to the physicians elected to active membership at the March meeting of the Association.

Nominations for Membership: The Secretary reported that the Executive Committee recommends for election as active members of the Association the following: Bruno DiClemente, M.D., 870 Smith Street, Providence, sponsored by Doctors Joseph DeLuca and John Mochnacky; Herbert Hans Myers, M.D., Mental Hygiene Services, Department of Social Welfare of Rhode Island, sponsored by Doctors Dominic L. Coppolino and Charles C. Goodman; Richard Lee Peters, M.D., 980 Reservoir Avenue, Cranston, sponsored by Doctors Joseph G. McWilliams and Charles E. Bryan; Michael Edward Scala, M.D., Providence, sponsored by Doctors Henry McCusker and Herbert E. Harris.

The Executive Committee also recommends the re-election to membership of Doctor Oscar Hyer of 115 Governor Street, Providence.

Introduction of Exhibitor: Doctor Francis H.

Chafee introduced the representative of the M&R Laboratories of Columbus, Ohio, who spoke briefly on the display presented by the company at the meeting for the information of the members of the Association.

Scientific Program: The President introduced Donald A. Dukelow of Chicago, Illinois, Consultant in School Health of the Bureau of Health Education of the American Medical Association, who spoke on "School Health Policies."

Doctor Dukelow emphasized the most important considerations in any School Health Program. The most important considerations in his opinion were:

1. Teamwork, cooperation and understanding between the administration and the Medical Department.
2. The recognition of responsibility on the part of the parents as it pertains to the health and welfare of children.

He pointed out that for the success of any school health program there must be complete cooperation between the department of education, the department of health and the local medical society and that the three agencies mentioned should participate in all phases of educational progress.

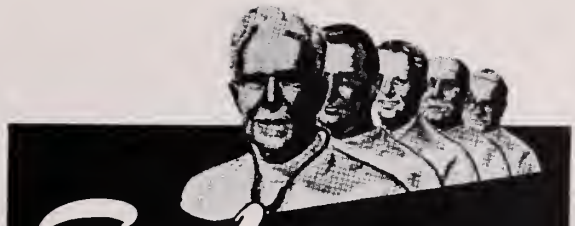
The second speaker of the evening was Doctor Sydney S. Gellis of Boston, Massachusetts, Assistant Professor of Pediatrics at Harvard Medical School.

Doctor Gellis talked on "Viral Hepatitis," a very timely subject in our community. He reviewed the interesting history of the disease as far back as the Civil War. Of interest was the fact that there were approximately twenty-three thousand cases of homologous serum jaundice during World War II. He discussed in detail both types of virus hepatitis, namely infectious hepatitis and homologous serum hepatitis. He stated that the mortality rate for infectious hepatitis is in the neighborhood of 0.2% and that the mortality rate of homologous serum hepatitis is approximately 0.2% to 19%. Both conditions are caused by a filterable virus that is resistant to heat.

Infectious hepatitis usually develops when the virus is taken by mouth or by inoculation. Homologous serum hepatitis develops only by a contaminated syringe or needle or other similar instrument. One attack of either type of hepatitis protects against subsequent attacks. Infectious hepatitis has reached epidemic proportions in the New England area especially among children and the fecal-oral route has been the method of spread.

The use of gamma globulin has been very effective in preventing the spread of this disease especially in families. He indicated that 35% to 40% of all adults are immune to infectious hepatitis but that there is no test available at the present time to determine susceptibility or immunity to the disease.

concluded on next page



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Approximately 0.01 cc. of gamma globulin per pound of body weight is sufficient to protect a given individual against infectious hepatitis for a three to six weeks period. Doctor Gellis strongly emphasized the importance of isolating every patient that is hospitalized and that strict isolation precautions must be maintained by all doctors, nurses, and other hospital personnel handling patients with this disease. Bed pan and syringe precautions are absolutely necessary. With regard to infectious hepatitis the patient's blood is less infectious than the stool. With regard to homologous serum jaundice, Doctor Gellis pointed out that all animals may carry the disease and that approximately 0.2% to 0.3% of the population are carriers of the virus of homologous serum hepatitis. It is transmitted from mother to child and through blood pools which often have become contaminated. Blood fractions are more hazardous in this respect than the original blood.

The meeting adjourned at 10:10 P.M.

Attendance was 96.

Collation was served.

Respectfully submitted,

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Approximately 400 physicians of Rhode Island and southeastern Massachusetts attended a dinner meeting at the Narragansett Hotel in Providence on May 25, sponsored jointly by the Rhode Island Medical Society and Pfizer Laboratories of Brooklyn, to hear Robert Vogeler describe the methods used by the communists to secure "confessions" from those whom they imprisoned. The lecture was considered one of the finest to be presented locally to focus attention on the dangers of communism, and the importance that every American should fight it in every way.

Mr. Vogeler was introduced to the physicians by Doctor Frank B. Cutts, president of the Rhode Island Medical Society. Head table guests, in addition to officers of the Society, included Captain F. K. Smith, medical officer in command at the Naval Air Station at Quonset, and Mr. Charles Dolan, assistant manager of professional relations of Pfizer Laboratories.

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AMERICAN MEDICAL ASSOCIATION

CLINICAL SESSION

November 29, 30, December 1, 2, 1955

MECHANICS HALL, BOSTON, MASS.

Abstracts

1) Abstracts of papers to be offered for presentation at the Clinical Session of the American Medical Association must be submitted in DUPLICATE before July 15, 1955, with an absolute deadline of August 1, 1955. They should be sent to Dr. Theodore L. Badger, Chairman of the Program Committee, Care of the Massachusetts Medical Society, 22 Fenway, Boston 15, Massachusetts.

2) Titles of papers alone will not be considered by the Program Committee, and abstracts of subjects for presentation must be presented as described below.

3) Abstracts must be limited to a 300-word summary including important data and conclusions. Charts and tables may be attached to aid in the selection of papers.

4) All abstracts and papers will be reviewed by the Program Committee and, when necessary, by experts in special fields in order to select those containing the most suitable material. FINAL SELECTION WILL BE ON A COMPETITIVE BASIS.

5) Subjects for presentation at the meetings may include clinical and scientific aspects of all branches of medicine and surgery, as well as the results of investigative work bearing on these subjects.

6) The names, titles, including hospital affiliations, and complete addresses of all authors must accompany each abstract. The author who is to present the paper must be the first author listed in the abstract.

7) Those wishing to present subjects of a confidential nature from the armed forces or other sources must clear the material through official channels BEFORE submitting the abstracts to the Chairman of the Program Committee.

8) It is urged that all who desire a place on the program of the Clinical Session submit their abstracts as early as possible in order to facilitate the work of the Program Committee in competitive selection of papers. The deadline, however, must be met in order to get the program ready. Remember the deadline is July 15, 1955.

Papers

1) Subsequent to review of the abstracts by the Program Committee, papers will be selected on a strictly competitive basis from among the abstracts for presentation at the Clinical Session. Authors will be notified by September 15, 1955, whether or not their papers are accepted for presentation.

2) Papers presented at the Clinical Session must be original contributions which have not been previously presented or published. All such papers should be considered as belonging exclusively to the American Medical Association and should not be submitted for publication elsewhere without the advance permission of the American Medical Association.

3) The time allotted for presentation of papers at the Clinical Session in November will be strictly limited by the committee to twenty minutes, including lantern slides, in order to permit five minutes of discussion following the paper.

THEODORE L. BADGER, M.D., *Chairman, Program Committee*

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THE LUNG CANCER SUSPECT

concluded from page 323

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BOOK REVIEWS

CURRENT THERAPY 1955. Edited by Howard F. Conn, M.D. W. B. Saunders Company, Phil., 1955. $11.00

This book is the seventh in a series of yearly editions, the purpose of which is to give concise, specific, and authoritative résumés of the most approved up-to-date treatment of clinical entities ranging all the way from *Abscess of the Brain* to *Zenkers Diverticula.*

To accomplish this purpose in a reasonable compass the articles are strictly limited to treatment (or prophylaxis), are necessarily somewhat arbitrary, and reference bibliography is omitted. The soundness of the treatment presented rests on the excellence of the some 290 authors of 339 monographs, chosen by the editor with the assistance of a distinguished board of twelve consulting editors. The authors represent high teaching positions in almost all the medical schools in the United States, as well as two in Canada and one each in Mexico and Puerto Rico, as well as high positions in other large medical centers. Many are recognized at once as known for their particular interest in, and contributions to, knowledge concerning the particular clinical entity discussed.

The editors show their fine hand in selection, but present no editorial bias.

It is an eminently practical and convenient reference book for any practitioner called upon to treat a generality of conditions. Naturally, with so many authors, the monographs vary in the degree of reader satisfaction but in general, the impression is given of quite complete practical instruction by thoughtful experts. Certain involved treatments, such as that of tuberculosis with all its ramifications, can be given in outline only. The monograph on the treatment of diabetes by the Joslin group offers a surprisingly complete coverage of the questions apt to come up in the treatment of a diabetic. Many other articles also give the impression of sufficient completeness to act as a satisfying guide to effective treatment when applied by any competent physician.

The present volume compared with that of 1954, shows almost 75% of the articles entirely rewritten. Of the remainder, many are unchanged where no new treatment has been elaborated during the year, some are slightly modified to include a new method or medication or modify the use of one previously mentioned. The present volume is condensed by about 200 pages compared with the 1954 volume, mainly by omitting essentially duplicating alternative methods by a different author writing about the same clinical entity. A few titles have been omitted, apparently because either the subject is covered under other titles, or the treatment is entirely nonspecific and symptomatic as in Dengue, or has no general interest except in very special locations, as Yaws.

Certainly if this book were universally followed, especially its strictures as to what is noncontributory or contraindicated, the treatment of many patients would be simplified and improved.

CHARLES J. HUTCHINSON, M.D.

REACTIONS WITH DRUG THERAPY by Harry L. Alexander, M.D. W. B. Saunders Company, Phil., 1955. $7.50

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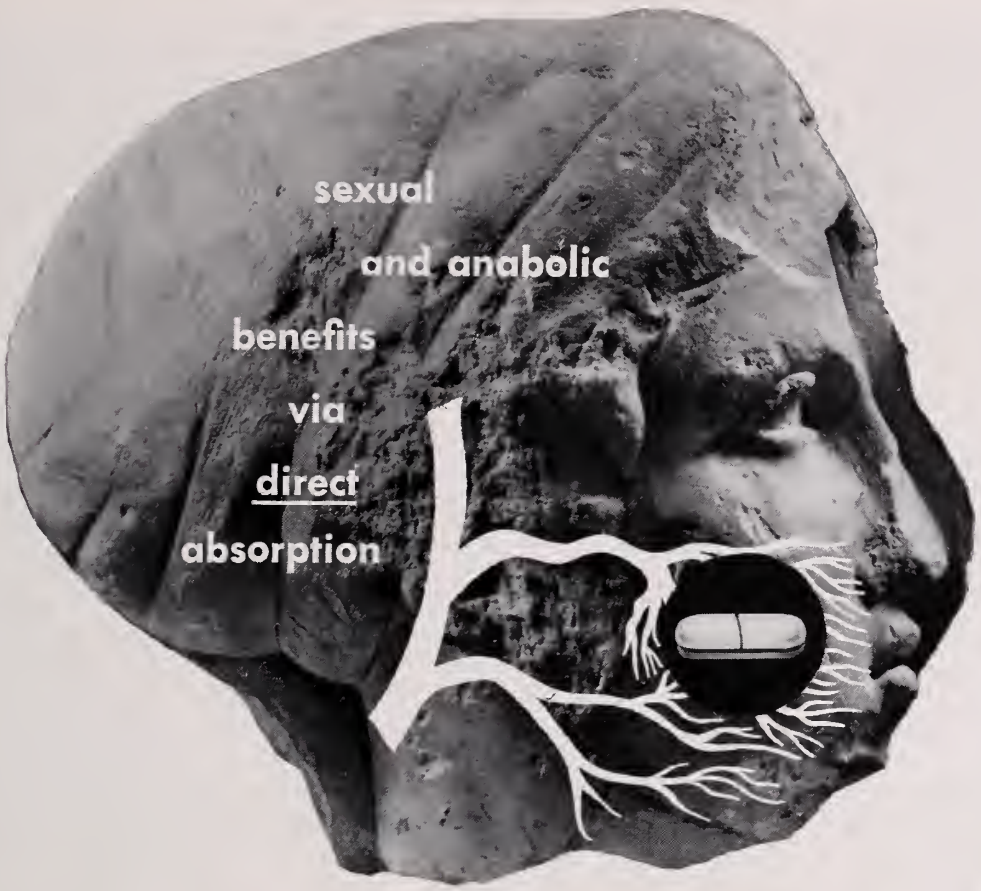
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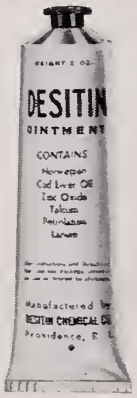
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3. Grayzel, H. G., Heimer, C. B., and Grayzel R. W.: New York St. J. M. 53:2233, 1953.
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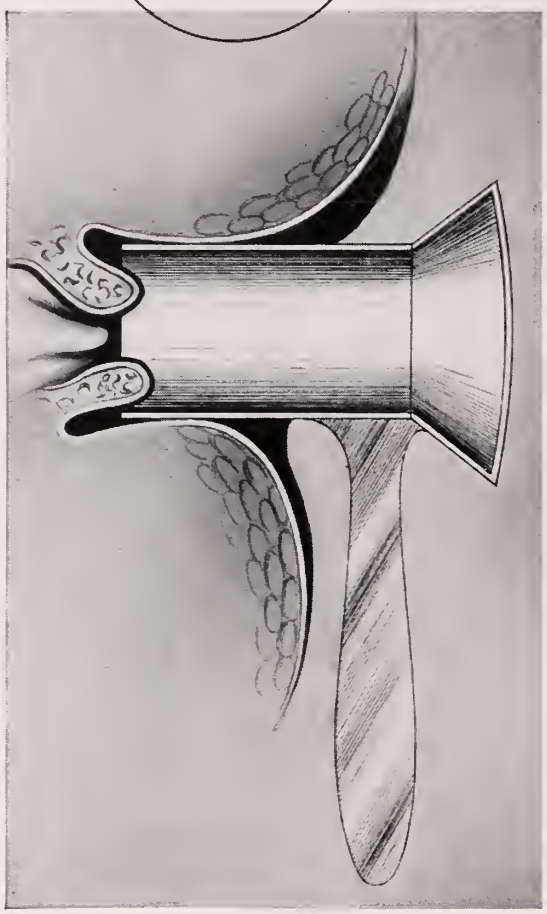
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(1) Payne, R. W.; Shetlar, M. R.; Farr, C. H.; Hellbaum, A. A., and Ishmael, W. K.: J. Lab. & Clin. Med. 45:331, 1955. (2) Bunim, J. J.; Williams, R. R., and Black, R. L.: J. Chron. Dis. 1:168, 1955. (3) Holbraak, W. P.: M. Clin. North America 39:405, 1955.

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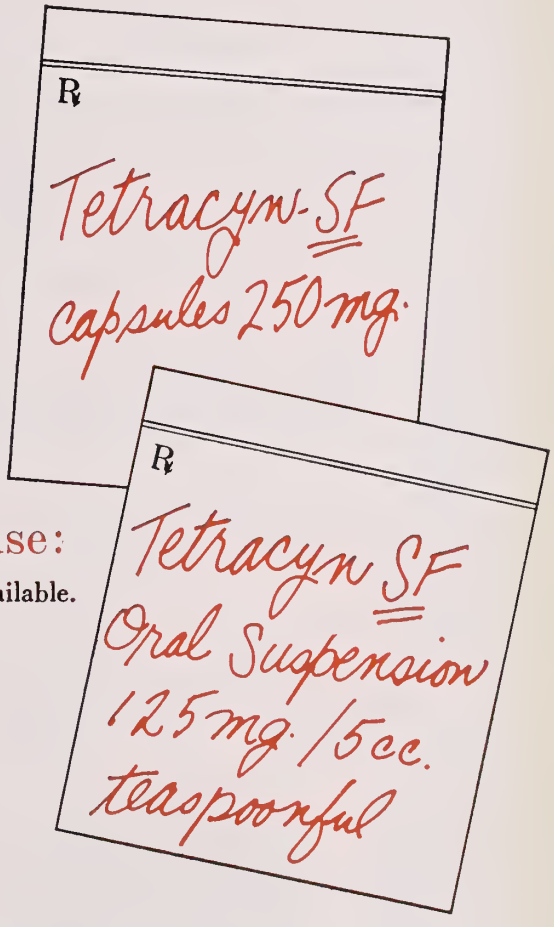
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3. Dumas, K. J.; Carlozzi, M., and Wright, W. A.: Antibiotic Med. *1*:296 (May) 1955.

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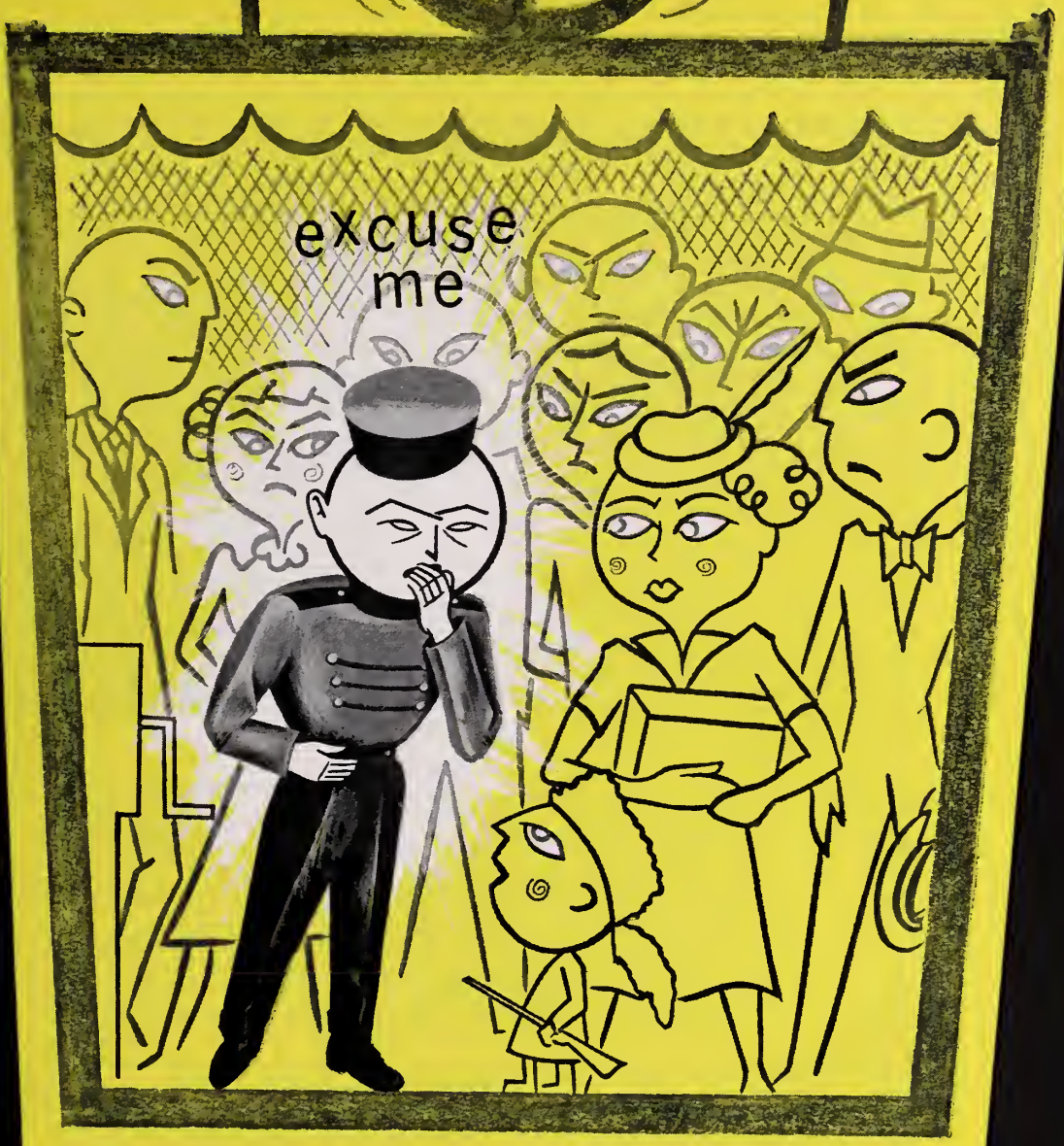
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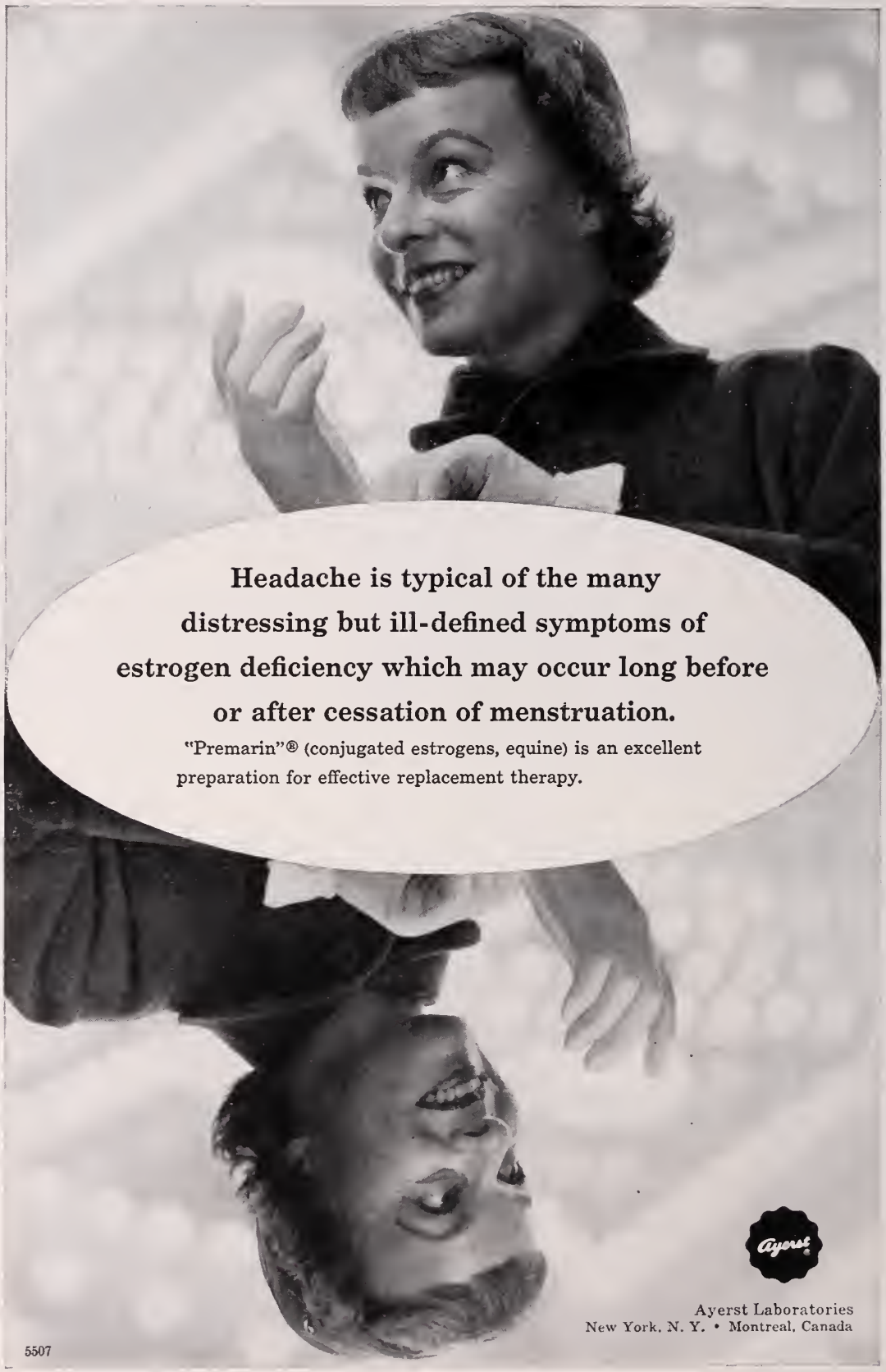
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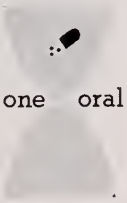
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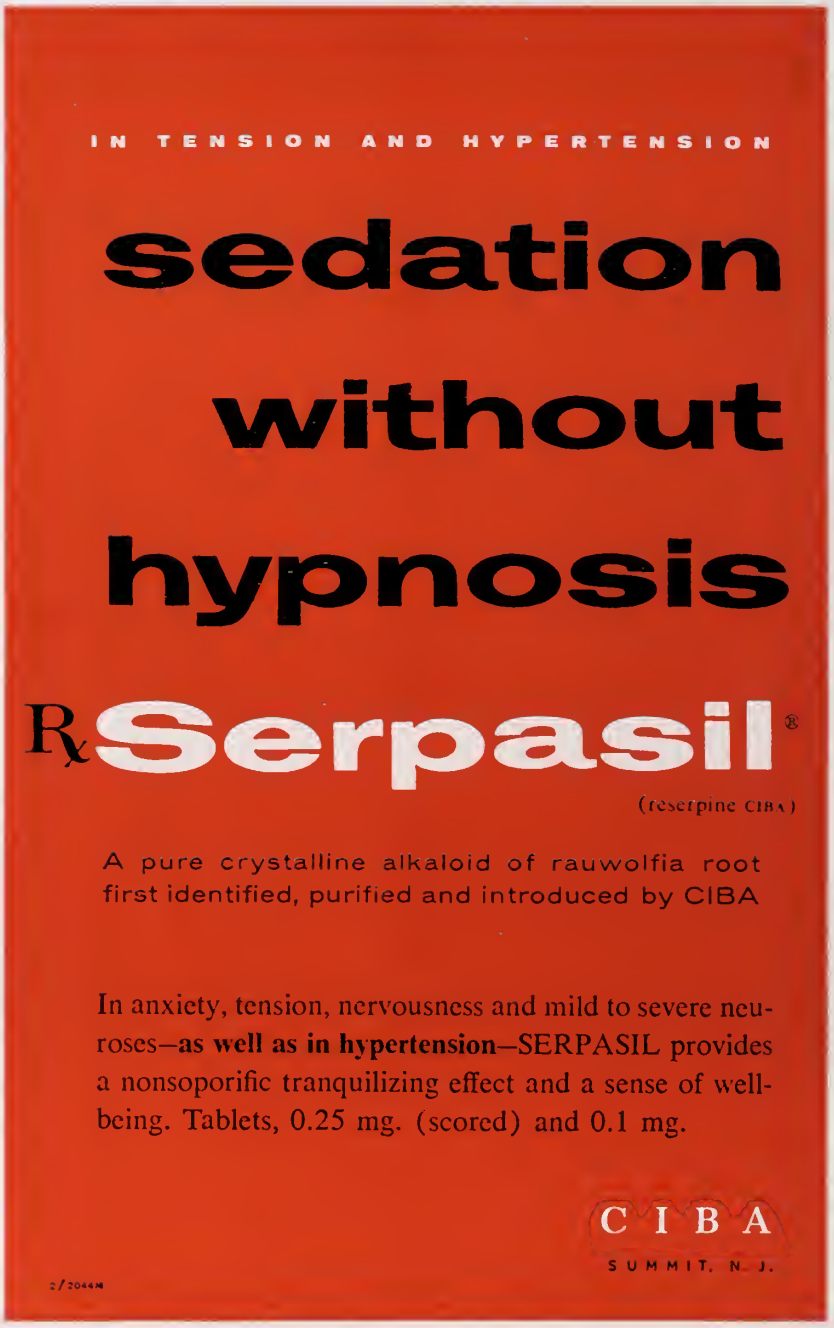
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VOL. XXXVIII JULY, 1955 NO. 7

THE USE AND ABUSE OF HORMONES*

SOMERS H. STURGIS, M.D.

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HORMONAL SUBSTANCES whether biologic or synthetic are powerful and effective tools when used correctly for indicated deficiencies. Some of them—as thyroid and insulin—have become well established, their action clearly defined and their optimal dosage not often exceeded. This is not as true of adrenal, pituitary and gonadal hormones. Not only is there a constant stream of new synthetic preparations and combinations, but there is also increasing evidence of complex interactions one upon another, and these developments make it well-nigh impossible for the clinician to select the correct dose of the optimal product, let alone anticipate in a given case the sure response. There is little wonder, then, that misuse of these potent substances keeps pace with the rapid increase in their use. It is difficult enough for a specialist and almost impossible for a man in general practice to keep up with all the new products. Actually, it is not of great importance. I cannot be convinced that any one estrogenic substance, for instance, is necessarily "better" than another. My advice would be to learn to use properly any one of many "good" preparations from a well-established pharmaceutical house; by personal trial to establish the dosage for the expected response—and stick to that particular product unless or until a preponderance of evidence accumulates overwhelmingly in favor of some other substance.

Thyroid. Obviously, there is no question at all about treatment for the clearly myxedematous. Many are convinced furthermore of the usefulness of thyroid in the presence of *any* symptom considered suggestive of thyroid lack. There are still others who counsel thyroid to tolerance in some conditions—as sterility—even though there are none of the subjective signs of deficiency. Such an extension of the use of exogenous hormones in apparently euthyroid states is open to strenuous criticism by those who claim that homeopathic doses are useless, and that anything larger creates a real danger of damping the patient's own thyroid-stimulating hormone and causing an eventual dependence on artificial substitution treatment. In the face of such wide diversity of opinion, it is only fair perhaps that I should state my own views. I pay little attention to basal metabolic rates. These all too often give a distorted picture. If radioactive iodine uptake or protein-bound iodine determinations are available they can be relied upon as a better measurement of thyroid function. But if these are not available, I search for such symptoms as tiredness, the need for more than eight hours sleep, constipation, poor circulation in hands and feet and so forth, plus the suggestive signs of dry hair and skin, white-spotted brittle nails, etc. If such are present I am willing to give a therapeutic trial of two to three months on generally no more than one and one-half to two grains daily. It is my strong clinical impression that this may not infrequently shorten prolonged intervals between menstrual periods and favor the chances of conception in otherwise normal couples.

I feel that prescribing thyroid solely to help reduce should be decried. I think the use of 3, 4 or 5 grains daily for prolonged periods is a gross misuse of the drug. Large doses inevitably suppress all endogenous function and create an artificial thyroid deficit so that the patient is indefinitely committed to the needless substitutive therapy.

Adrenal. I shall not try to review the known uses and dosage of adrenal cortical hormones not only because as a gynecologist I am ill-fitted to do this but also because perhaps the full knowledge of these useful substances has not yet been gained. Newer cortical compounds are being synthetized continually and some of them are proving considerably more potent, milligram for milligram, than cortisone or hydrocortisone. No matter what preparation is to be utilized it is worth remembering

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that the constant use of an effective adrenal cortical hormone inevitably involves over a long period of time the possibility of deleterious effects due to sodium retention and the chance of producing these side effects must be weighed against the original indication for use of the drugs. I would only state once more the warning that these substances carry the ability to suppress the pituitary ACTH of the patient and thus rendering him a relatively adrenal-deficient individual. This response has been put to use in cases of adrenal hyperplasia where the correct dose of cortisone can be found to reduce the overproduction of corticoids in cases with signs of masculinization or virilization. There is no excuse, however, for using these compounds unless a laboratory has been able to demonstrate increased values of 17 Ketosteroids and oxysteroids in the urinary excretion.

In some women with hirsutism, obesity and amenorrhea who have the so-called polycystic ovary syndrome of Stein and Leventhal, it is possible to show a relationship to hyperactive adrenal glands, and the prolonged use of small doses of cortisone (as 50 mgs. by mouth daily for 30 days, then a reduction to a maintenance dose of 25 mgs. a day) has been found occasionally to be helpful in the return of ovarian function. I believe it would be wholly wrong, however, to use this dose for any woman who is a little hirsute, possibly slightly overweight, and whose periods are somewhat irregular. Such cases should be properly evaluated by a team with an endocrine laboratory available to assay for the levels of steroids and the effect of the medication.

Pituitary. It is well to remember that all pituitary hormones are large protein molecules, none of them have been synthetized, we have no formulae for any as yet. They all are relatively impure. They have been put to two uses. First, they may be used as a stimulating test dose to assay the potential function of a target organ. Thus, thyroid stimulating hormone is useful to judge what potential function there may be in a gland that previously has been suppressed for a prolonged time by large doses of thyroid. It is, of course, necessary to take such a patient off thyroid for eight weeks or more before such evaluation.

In a not unsimilar fashion ACTH has been used recently in intramuscular or intravenous dosage to measure the possible function of the adrenals. Where adrenal hyperfunction has been demonstrated, this is sometimes an aid in differentiation between a functioning adenoma or carcinoma and a mere hyperplasia. The tumors of the adrenal are generally independent of pituitary stimulation and show no increase in urinary corticoid excretion following such a dose, whereas, the hyperplasias occasionally are picked out by their ability to react with an increase in urinary corticoids to the test dose. There is no particular reason for using either TSH or ACTH therapeutically since the product of their target organs, thyroid and adrenal corticoids, is more easily given as an oral preparation for deficient states.

The gonadatropic preparations have long been on the market. These come from three sources: from animal pituitary glands, from pregnant mare's serum, and from the urine or placenta or pregnant women. Theoretically, when gonadal inactivity is not due to ovarian or testicular failure but to lack of proper pituitary stimulation, then substituted gonadatropic therapy should be the treatment of choice. Unfortunately, however, the preparations that derive from the pituitary of slaughterhouse animals carry the probability of anti-hormone development which will inevitably and automatically limit the repetition of their use. Unfortunately, also, the purification procedures necessary before these substances are proper for clinical use significantly alter and reduce the potency of this material; there has been thus far no substantiated evidence that commercial preparations from animal pituitaries have ever consistently caused ovulation in a female or spermatogenesis in a male. Not rarely in an amenorrheic woman large doses of such compounds may bring about an apparent menstrual flow. I do not believe that we can hope that this will bring about ovulation, however, and in my own practice I have practically given up the use of any of the pituitary preparations.

Ovarian. The two ovarian hormones to be considered are estrogen and progesterone. Estrogen is widespread throughout all nature. It is found in birds and insects, it is present in potatoes and pussy willows, it has been extracted from lignite and from the depths of the Dead Sea. Perhaps this is why to nature has been assigned a maternal role in deference to the ubiquity of what is generally called the female sex hormone. In the human, it affects a wide variety of tissues and organs; not only does it maintain and develop all parts of the female reproductive system, but also it affects the skin, the hair, the skeletal system and its influence on circulation is apparent in the neurovascular phenomenon of hot flashes at the time when failing ovaries result in a draining off from the system of this powerful hormone. Estrogens are prepared both biologically and synthetically for clinical use. It seems to me wise indeed to have well in mind whether the use of this hormone is for substitution, for diagnosis, or to augment a presumed relative deficiency from the patient's own ovaries. Misuse of this hormone perhaps will be less common if we can establish securely the reasons for its use and the expected response. In a woman's usual life span it can be expected that she will have the benefit of

estrogen continuously albeit in cyclic waves from something around twelve years to the time of the climacteric, between forty-five and fifty. If a young girl is born without any ovaries at all, the so-called Turner's Syndrome or ovarian agenesis, it seems only proper that she should be given the benefit of estrogen continuously up to the end of the fifth decade. This will prevent a premature aging of the skin and hair and give these unfortunate girls at least the chance psychologically to feel that they belong to the female side of society. Two to five milligrams a day may be given for periods of four weeks, at which time the dose should be stopped for eight to ten days until withdrawal bleeding from the stimulated endometrium occurs, when a similar cycle of therapy is again repeated. I believe also that any young girl castrated before the age of thirty for any situation other than malignancy should probably be allowed the benefit of estrogen in the same sort of a dosage. There is considerable difference of opinion concerning treatment of the normal menopause. For myself I believe that such women if they have socially disabling hot flashes should get sufficient estrogen to control these disturbing features of the "change." I am not convinced that continuation of this therapy puts off the eventual adjustment that generally takes place within one, two, three, or four years. I have known patients however, who still need estrogen to control disabling hot flashes fifteen years after the change of life. How much of such dependency is psychosomatic, however, is difficult to evaluate. I do not consider it a misuse of this hormone if trial without medication proves the recurrence of severe and distressful symptoms. These then, are some of the uses of estrogen for substitution therapy. I don't think it matters at all what kind of preparation is used. I have mentioned stilbestrol because it is more or less standard. The best advice is to find out what dose of a preferred preparation will give the needed results and stick to it.

Estrogen can be used for diagnosis, too. In a girl eighteen years old or more who has never had a period, if it is desirable to know unquestionably whether or not she has the rare condition of a congenital absence of the uterus, one or two milligrams of stilbestrol a day for three to four weeks may be given and then if withdrawal bleeding follows cessation of treatment, it proves that there is a uterus capable of response. Dysmenorrhea is a disabling symptom in perhaps one-sixth of high school and college girls. Estrogen can be used as a diagnostic test in this way. One mg. of stilbestrol orally starting the first night of the menstrual cycle and continued for three weeks in most cases will cause an anovulatory withdrawal type of uterine bleeding about six to eight days after stopping the course of therapy. If this is a flow completely lacking in the expected menstrual discomfort and cramps, it tends to suggest that there is no mechanical or organic pelvic cause for the severe pain. In such a situation then, it is relatively safe to conclude that the cramps are due to functional, i.e. psychosomatic manifestations of the child's adolescence. I do not believe that estrogen is the treatment for dysmenorrhea. In the first place, the dose that I have outlined cannot be used more than every other month to cause an anovulatory pain-free menstruation. I am convinced that the fundamental basic cause for such severe cramps is one of maladjustment to maturity often involved in the child's reaction to her mother and any such induced cramp-free period does not strike at the basic cause of dysmenorrhea. It is, however, an important crutch for support that can be used at times during the year under the direction of the girl's doctor. These then, are examples in the use of estrogen for diagnosis.

By far, the more frequent indications for the use of estrogen are to be found in the area of augmentation of a relatively deficient ovarian function. Thus, in those that have had three consecutive miscarriages, I am of the school that believes that the regimen of progressively increasing stilbestrol treatment outlined by Doctor Smith in Brookline, is definitely of value in enhancing the possibility of future salvage. I would like to interpose however, that the use of stilbestrol after bleeding has started in pregnancy is absolutely of no value whatsoever.

Since estrogen is responsible for maintaining the tubes, the uterus and endometrium and the cervix and vagina in optimal condition, it is obviously an important element in the proper functioning of these organs in any infertility problem. Let it be noted that anything more than one-tenth of a milligram of stilbestrol or its equivalent through the cycle, however, given in order to augment the function of these organs will be useless in regard to sterility since more than this dose in susceptible individuals may be sufficient to suppress the pituitary gonadatropic production and prevent ovulation altogether. For senile vaginitis, it seems more appropriate to use a small dose locally (as five-tenths of a milligram of stilbestrol in a vaginal suppository) to increase the tissue resistence of the vaginal mucosa than to use any systemic medication for this purpose. These latter uses of estrogen illustrate some of the ways in which this drug may serve to augment whatever the organism may be producing itself.

Before leaving the subject of estrogen medication I would like to place myself on record with those that feel there is no definite evidence as yet that estrogen alone ever causes cancer. It is my belief that there must be an intrinsic factor present in the individual herself and that the use of estrogen is not to be condemned as long as the patient is

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continually under the care of her physician: I do not think that anybody should go more than six months without checking with her doctor if she is on estrogen but I am at present convinced that with such frequent check-ups there is no harm or danger in continuing its use in indicated doses for necessary needs because of the cancer menace.

Progesterone. Progesterone therapy is indicated whenever there is evidence of ovulation failure that is primarily responsible for delayed, infrequent or prolonged flows. When tumors, infections, tuberculosis, endometriosis and other organic pelvic diseases have been ruled out there is one common denominator for all these three complaints; in all, the primary deficiency is failure of ovulation and consequently a non-production of progesterone. One syndrome that must be excepted from this statement is the Stein-Leventhal polycystic ovaries mentioned previously. Aside from the use of cortisone mentioned above hormone therapy is unavailing; surgical measures are indicated to make it possible for ovarian follicles once more to reach maturity and rupture through the ovarian cortex. Since in my experience there are yet no effective preparations of lutenizing hormone, the only valid therapy for this type of menstrual abnormality is the cyclic use of progesterone. If the ovaries are producing enough estrogen to prime the endometrium, then a course of progesterone repeated every four weeks should be enough to produce artificial periods. The dose should be of the order of either 50 mgs. I.M. in one dose, or 20 mgs. per day absorbed through the buccal mucosa for five days, or 50 mgs. of the anhydrohydroxyprogesterone given orally for five days. If, however, any of these doses fails to give a withdrawal flow, then it is necessary to prime the endometrium first with estrogen in a dose of perhaps 1 mg. of stilbestrol a day for three weeks. After a withdrawal flow has been established by this dose then the estrogen priming may be reduced consecutively with the hope that the patient's own pituitary-ovarian axis will take over and produce eventually spontaneous flows following ovulation.

It has been recognized by clinicians that emotional tension and psychosomatic states by some ill-defined mechanism may block the release of pituitary gonadatropins, especially LH, in many cases. Some of these individuals may resume normal cycles after confident reassurance alone; others need definitive psychiatric investigation. The induction of artificial flows with progesterone or in combination with estrogen, however, is almost the only regime outside of psychological support that I feel is justified. I want to stress the fact that sufficient progesterone must be given to evaluate the response of the endometrium with withdrawal bleeding. Less than the doses I have indicated may be ineffective and only discourage both doctor and patient as to the efficacy of continuing hormone control. Progesterone is a relatively innocuous preparation but in my opinion it need not ever be used for more than four or five days at a time in a planned cyclic therapy for the purposes I have outlined above. I believe that the use of small doses of progesterone for a threatened miscarriage, once bleeding has been established, is futile and unrewarding and I think this misuse of the hormone is too common at the present time.

Testicular. The use of testicular hormones is not always considered to be the province of the gynecologist. There are those who maintain that male hormones should never be used for the female. With this I do not agree. Testosterone used orally in small amounts, such as 5 mgs. of the methyl substance a day can be helpful and provide a tonic effect for many premenopausal and menopausal women. Further than this, it is my clinical impression that testosterone in small doses may reduce the occasional hemorrhages due to endometrial hyperplasia during these premenopausal years. Testosterone in the female who shows severe symptoms from osteoporosis many years postmenopausally can be given with impunity at a time when the posible hirsutism that may develop is of no consequence to the individual. A small dose of testosterone, namely 5 mgs. of methyl solution orally, can also be given for long periods of time and with apparent excellent effect in many cases of endometriosis. This is in a dose range that will not prevent ovulation but appears to have a definite effect on endometrial implants on the peritoneum. Those who give a dose larger than 5 or possibly 10 mgs. a day of the oral preparation for any length of time are courting the possibility of virilism in the form of growth of hair, change of voice, etc. which must be thoughtfully balanced against the gain from the medication used.

In the male I believe that the use of testosterone in general is to be condemned. It is only in the hypogonad or eunuchoid states where substitution for deficient testes is of paramount importance, that testosterone can be condoned. I have known those who have requested injections of testosterone for many years on the basis that it made them more virile and more masculine without realizing that the dose may have only suppressed their own pituitary gonadatropins and maintained their own gonads in the state of relative inactivity. The male climacteric is a vague and poorly defined situation: there have been few that I have known about who have benefited materially from the injection of male hormone due to a supposed gonadal deficiency from the fifth decade on.

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A REAPPRAISAL OF MEDICO-ECONOMIC PROBLEMS*

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THIS CONFERENCE, and the meetings of the reference committees of the House of Delegates of the American Medical Association, are the only occasions that afford the medical profession an opportunity to discuss the socio-economic aspects of medical care at the national level.

The socio-economic factors affecting medicine are growing in importance, size and urgency with each passing year and they require increasing attention from every member of the profession.

It is to be regretted, therefore, that so little time and effort is expended in appraising, analyzing, and solving these problems at state and county levels.

For several years I have advocated the abolition of the scientific meeting of the county society in favor of a socio-economic one. I have urged more attention to socio-economic aspects at the semi-annual and annual meetings of the *State* Society.

Time was when the local and the state society meetings—plus a few medical journals—offered the chief source of current medical experience and postgraduate information. The speaker's presentation, case discussion, question and answer period, and the occasion for personal contact, gave the busy doctor an opportunity to keep abreast of the ever-changing medical scene.

With the passing years, however, this situation no longer obtains! Everyone in medicine belongs to some group, whether he is a specialist or a general practitioner, an industrial physician or a public health administrator. Each has several good medical journals readily available to him and devoted to his special interest.

Tape recordings, library loan services, closed circuit television, clinico-pathological conferences and study groups, obviate the need for many scientific meetings at the county level.

Surely we are capable of organizing study committees in our county societies whose task it would be to investigate, correlate, evaluate and summarize the pros and cons of all the various aspects of our socio-economic problems, and develop material for the regular county meetings.

Such committees could prepare panel discussions, or make such reports as to enable the rank and file of the profession to develop properly a truly realistic and objective attitude on the various aspects of any subjects discussed.

Too often we find, in staff room discussions, an abysmal ignorance of important issues. The opinions expressed frequently result in compounding the misinterpretations — and eventually develop unjustified criticism of the actions of organized medicine.

When, on occasion, I have been told by a physician, "The A.M.A. doesn't speak for me in this instance," I usually inquire if my colleague had made a study of the question, and whether or not he had ever discussed it objectively at a district society meeting. The answer invariably was "No." He and a few of his friends were basing their opinions on hearsay, inadequate information and, influenced by their emotional reactions, frequently came to an entirely different conclusion than they would have reached if they were in possession of more specific information.

The delegates to the American Medical Association do their very best to interpret the attitude of their constituents, but until the county societies give adequate attention to the questions before us—develop an official attitude which, in turn, can be communicated to the state society and through them to their delegates to the American Medical Association—we cannot hope for complete assurance that we truly speak for medicine.

The solution for medicine's problems should emanate from the grass roots. No pronouncement of principle, no code of ethics or basic philosophies, nor official attitude developed at the national level can be effective without implementation down the line.

The A.M.A. cannot dictate, it can merely point the way. The authority comes from the membership. Hence it is imperative that all physicians become thoroughly and completely informed as to all facets of all problems.

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This requires a degree of effort which so far too few physicians have been willing to give. Many tell me they are "too busy." They imply that they are busy with that first duty of every physician, i.e., care of the patient. They are not too busy, however, to do all the things necessary for their own economic welfare. They manage to find time to buy a car, arrange for a vacation, pay their taxes and do all the things which, if neglected, would result in their own economic chaos. When it comes to medicine's economic welfare—they "let George do it" until something occurs that they don't like. They then speedily and indignantly demand to know what happened and what is to be done about it.

Many of our state associations sponsor an annual conference of secretaries and other officers of their constituent county societies. Such meetings are only a step in the direction to which I point. It is as impossible to absorb all the non-scientific problems of medicine in a one-day session as it is to assimilate all knowledge of medicine by attending one meeting of the American Medical Association.

Our task is one of continuous education. We cannot leave the task to the county society without offering aid to enable each such society to really tackle the problems and come up with some worthwhile ideas.

The state associations are organized with central offices and usually with full-time staffs of trained workers. County societies are for the most part not organized with similar facilities. Therefore, our state associations have an opportunity to render greater service to their district groups, and thereby to all medicine by lending a helping hand to the county societies, and particularly in the formation of study committees.

I would like to enumerate at this time some of the subjects that could well be the basis for attention by study committees of the county society. In some areas, no doubt, these questions have been solved, in others they may not be germane, but in many areas they are and will remain serious issues.

I make no pretense of knowing the correct answers and, in some cases, any answer at all, but I am convinced that with proper attention many of these issues can be speedily and effectively settled.

1. *Voluntary Health Insurance*

How well do the members of your constituent society understand the functions and *modus operandi* of Voluntary Health Insurance? Do they realize and appreciate their obligation and that of their patients to properly utilize but not to *overutilize* these plans? Is it realized that double coverage, excess coverage and the utilization of several plans for the same procedure constitute a serious problem in the insurance field?

Is it fully appreciated that this type of insurance is based upon the "reimbursement" principle and that the patient is to be reimbursed only to the extent of his actual loss? These problems require immediate attention.

2. *Social Security*

How do your colleagues really feel about Social Security? Are they fully informed as to what it does and does not do? Is it appreciated that benefits apply only after sixty-five and that one may not earn more than $1200.00 a year in order to qualify?

What will be the probable moves in Congress to extend and develop further coverage under Social Security?

3. *Re-Insurance*

Just what is re-insurance? Will it do what its proponents expect? Are there unsound experimental practices advocated which may eventuate the development of government subsidy and compulsory health insurance? How can re-insurance provide a means for making insurable what otherwise would be an uninsurable risk? Can you appreciate the effect such re-insurance will have upon the retardation of and/or the expansion of present Voluntary Health Insurance Plans?

4. *Temporary Disability Compensation*

Four states have laws that permit a worker while unemployed through illness to collect cash benefits for specified periods of time. Do your members know how these laws operate, and the medical problems involved in them? If such legislation is proposed in your state how well would your members be informed to discuss the advantages and disadvantages of a monopolistic state program *versus* a competitive program between the state and the insurance industry?

5. *Workmen's Compensation*

Most of the medical profession should be and in most cases are fully cognizant of the operation of workmen's compensation laws in each state. However, it is well to remember that constant vigilance is needed to guard against abuses by both patients and doctors.

Some years ago it was the not-too-successful physician in the community who found means to keep an injured patient under treatment for his own and the patient's benefit. Now we find that even some able and prominent men will, on occasion, rely on their acceptable background in the hope that their activities would thus be free from suspicion. These men compound the problem of the proper adjudication of workmen's compensation claims. Abuses under the workmen's compensation law require as much attention from the profession as fee splitting, ghost surgery or any other questionable practices. The insurance industry has the right to expect full cooperation from the medical profession.

6. *Public Relations*

Public relations committees have been organized at the state level, but the county societies can well implement more effective techniques in *their* localities. The root of all bad physician public relations rests squarely on the individual M.D. In this connection, it should be noted that the doctor is all too often missing from committees of the Chamber of Commerce and other civic bodies. Doctors should remember that they have duties as *citizens* and that their community needs the help and guidance that physicians are so well equipped by education and training to give. Why are we so deficient in this field?

7. *Malpractice*

Recently we have seen attempts to develop the group coverage technique for protection against malpractice suits in an effort to reduce the *cost*. Malpractice protection will always be costly until the cause of the excessive cost is corrected at its source, i.e., better conduct and less loose talk among local doctors.

Local committees can and should do much in this regard in cooperation with the grievance committees of a state society as we have done in Rhode Island.

8. *Financing Hospital Care*

The commission on financing hospital care has just issued a three-volume report which should be required reading for a special committee of every county society. This committee should not only prepare a digest of the findings and recommendations, but assess the result in terms of their local situation.

Only by this method can the local physicians appreciate the extent and the direction of the forces at work around them and recognize the trend of the times. It may be found desirable to implement and support *certain* objectives; to modify and compromise in *other* objectives not in conformity with medical opinion and judgment. Too often we belatedly discover well-advanced plans to which we cannot acquiesce, and which have been developed while we were busy elsewhere.

One of the recommendations of the commission on financing hospital care was the development of diagnostic and therapeutic facilities for ambulatory patients at the hospital. Another was that the hospital encourage the inclusion of outpatient service in the prepayment plans.

I can well envision areas where such recommendations might necessarily be applicable, but I can equally well envision areas where they would not.

It would be extremely helpful for the doctors in general to be cognizant of these trends and to know wherein these recommendations would be *necessary and acceptable* and thus develop cooperation; on the other hand it is mandatory to know equally well the areas in which they are inapplicable and by early participation help modify the plans to a degree acceptable.

It is important for us all to recognize that financing hospital care has become a major problem in this country. Many of our voluntary hospitals are private corporations and operate with an ever increasing deficit. These corporations turn to the people of the community, to business and industry for financial support, and then in addition expect the state government to meet their deficits.

How long will state governments continue to pay for increasing hospital deficits without some voice in the direction and control of hospital operation? We in medicine oppose state and government control, but we had best give this matter some thought.

9. *Hospital-Physician Relationship*

A few years ago the American Medical Association adopted a policy toward hospital-physician relationships and suggested to the state societies that they, in turn, form committees to consider these relationships. Some state societies have had little success with such committees which again goes to prove that no statement of purpose—no matter how nobly phrased or loftily conceived—can substitute for an activity by men of purpose acting honestly and fearlessly to evaluate and adjudicate local issues.

The American Hospital Association publishes a booklet for the governing boards of the hospitals called TRUSTEE. In the March, 1954 issue an article is titled, *The Search for a Trustee* and says in part, "Changes make desirable a review of the characteristics to be sought by a hospital in the person it elects to the Board of Trustees. It is entirely reasonable that the people who are the main financial support of an organization should be represented on its governing board. In the past this has meant that the members of the hospital Board of Trustees were frequently chosen from wealthy families of the community and were apt to hold their position on the board indefinitely. Also they frequently considered trusteeship simply as a social distinction and contributed little except attendance at meetings and help in meeting annual deficits."

"The membership on the board should be sufficiently diversified to be representative in the area it serves. Provisions should be made for bringing new persons and ideas into it at regular intervals."

How well do the hospitals in your areas subscribe to the above?

In another issue of TRUSTEE the hospital's duty to the staff physician is discussed and I quote in part. "Protection from discrimination on the grounds of race, creed or color should be afforded

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by the hospital trustees. Nor should the physician have to go about in fear of arbitrary or capricious action by the medical staff or the trustees of the hospital that might terminate his appointment or curtail his privileges without cause."

Again "Neither the administration nor the medical staff has any right to interfere with his (the doctor) management of his patient. So long as he does not exceed his privileges or violate proper practice, the physician has the right to practice his profession as he sees fit in the hospital. The physician has a *moral* though *no legal* right to security of tenure on the medical staff of a hospital if he has abided by the rules and regulations of the hospital, practiced good medicine and maintained exemplary conduct."

These are presumed to be sincere and honest statements and are indeed welcome. They should be observed to the letter. Whether or not they are truly observed is the responsibility of the local physicians.

10. *Fee Splitting*

The existence of evil in a given community does not necessarily bring its citizens in general into disrepute, but the whole profession of medicine is so easily maligned that rascality in the profession should be dealt with where found. There would then be no need for national action with its inevitable reflected onus on the entire profession and universal castigation by press and periodicals.

Too often local action which should and could be taken is deferred because of a lack of courage and unwillingness to face the issue boldly and honestly.

Social, economic, political or professional factors deter some who could act and the same conditions protect others from local action.

All the pronouncements from the profession at the national level and all the codes of ethics of the hospital and the profession are valueless until implemented locally.

11. *Specialization and Hospital Privileges*

Doctor E. J. McCormick, immediate past president of the American Medical Association addressing the Academy of General Practice in Cleveland in March, 1954 said, "Hospitals should not be centers for specialists and it never was the ideal of the American Medical Association or the American College of Surgeons or any of the boards to establish a system whereby qualified physicians would be denied the facilities necessary to give good medical care to the people."

Medical Economics quoted Doctor George M. Lewis of New York as follows: "It is true that the onus of proof might well be on a non-certified applicant for a hospital position to demonstrate his competence. However, once that competence has been proved, either through long service or otherwise, discrimination against him as non-certified cannot be justified. The board certificate should never be used as a weapon." Let us make that a reality—not just a statement!

The joint commission on accreditation of hospitals in Bulletin No. 7 states, "Formal resident training, College of Surgeons Fellowship or Board certification are all excellent criteria and the physician desiring to do surgery should be encouraged to set them as his goals. Recognition of the worthwhileness of the above criteria cannot be overemphasized. . . . The frank, brutal truth remains, however, that they sometimes, though not often, are only a piece of paper; that time can warp a man's judgment and poor health can slow the facilities of a surgeon's hands."

"Merit alone is the only criteria for judging a physician's surgical ability."

The above quotations all reflect sincere honest opinion and, if properly applied, would obviate a great many of the present day inequities in hospital staff appointments.

How often, however, have the very criteria designed to protect doctor, hospital and patient, been subverted at the local level by various selfish forces acting under the guise of "elevating standards."

12. *Internships*

Does your hospital get the interns it needs and requires, or does the neighboring medical center or university hospital get an inordinate number? What can you do to make your hospital attractive for intern training? What about the problems of attracting young men to rural areas under general practice?

These issues need attention not only from state licensure boards and hospital trustees, but from the profession itself. It is the profession's responsibility to develop an adequate supply of medical men available for the smaller communities.

13. *Economics*

Probably no one knows less about economics and business practice than the doctor. Medical schools and hospitals have been slow to stress ethics and economics.

New doctors in the community could profit by contact with the local committee offering indoctrination and instruction in the social-economic environment.

14. *Osteopathy*

IF Osteopathy has discovered that the "Osteopathic Lesion" does not now and never did exist, should not the House of Delegates of the Osteopathic Association promulgate this fact and *not* the House of Delegates of the A.M.A.?

IF the cultist label is to be abolished, should not the Osteopathic Association correct their college

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OBSTRUCTIVE JAUNDICE DUE TO CHLORPROMAZINE*

A Case Report

HAROLD W. HARROWER, M.D. and PHILIP COOPER, M.D.

The Authors. *Harold W. Harrower, M.D., Section Chief, General Surgery, and Philip Cooper, M.D., Chief, Surgical Service, Veterans Administration Hospital, Providence, and Associate Professor of Clinical Surgery, Boston University School of Medicine, Boston, Massachusetts.*

JAUNDICE can occur as a side effect of chlorpromazine therapy.[1-9] Since this drug is being widely employed with increasing frequency in the treatment of many different disorders, jaundice due to its administration will be seen more often. The jaundice produced by chlorpromazine is frequently obstructive in type and may be associated with a variety of systemic and gastrointestinal symptoms which make differential diagnosis quite difficult.[1-6] A case of this nature was recently encountered and is presented below.

Present Illness: The patient, R.V., a forty-one-year-old white male, was entirely well until one year ago when he began to have recurrent episodes of aching pain in the posterior neck. The pain was occasionally throbbing in nature and would sometimes radiate to the scalp on the right side. This pain was not associated with auditory, visual or gastrointestinal symptoms, and was usually relieved by two aspirin tablets. Attacks tended to occur on weekdays, being rare on weekends. The patient consulted many physicians but said that no definite diagnosis had been made.

About six weeks prior to admission excessive fatigue was noted. This symptom persisted and the patient consulted his personal physician, who prescribed a course of chlorpromazine. Treatment started on September 18, and consisted of one 25 mg. tablet twice a day. While on this therapy, fatigue became more marked; anorexia, malaise and a nagging ache in the lumbar area appeared. After some twenty-one days of chlorpromazine medication, the patient observed that his urine was very dark in color. The following day he noticed a yellowness of the skin and sclerae. At this time also he experienced intermittent sensations of sweatiness, chilliness, feverishness, and discomfort in the upper abdomen. Chlorpromazine was discontinued and several days later, on October 12, the patient was admitted to another hospital.

Careful questioning failed to reveal any history of exposure to hepatotoxic agents or drugs which may cause liver damage, other than chlorpromazine. There were no known contacts with any patients with jaundice or symptoms suggestive of hepatitis in the past six months. There was no history of having received any parenteral injections during the same period. The patient also denied any history or symptoms at all suggestive of previous liver disease.

Examination revealed a middle-aged man with slight icterus. He appeared otherwise in good general physicial condition. There was mild tenderness over the gall bladder area and the liver was slightly enlarged. Chest X ray was not remarkable. The hemoglobin, red blood count, prothrombin time, blood glucose, urea nitrogen, and total protein and A/G ratio were within normal limits. The blood Hinton was negative. One stool specimen failed to reveal any ova or parasites. Urine examination showed bile and a trace of albumin. The white blood count was 12,700 with 39% polymorphonuclear leukocytes, 19% lymphocytes, 3% monocytes, and 39% eosinophiles. The total eosinophil count was 4,000. Serum bilirubin was 3.7 mg. % total, and 2.1 mg. % direct. Thymol turbidity was two units, and the cephalin flocculation test was negative. An heterophil agglutination test was negative in 1:10 dilution. The patient ran an afebrile course with slight symptomatic improvement, and after three days, on October 15, was transferred to the Veterans Administration Hospital, Providence, R. I.

Past History and Family History: Noncontributory except for appendectomy 15 years ago.

Physical Examination: The patient was well nourished and well developed. He did not appear either acutely or chronically ill. The skin and

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Acknowledgment is made to Dr. Roswell W. Phillips, Assistant Chief of Medicine, for performing the liver biopsy, and to Dr. Richard B. Singer, Chief of Laboratory Service, for the pathology interpretation of the biopsy material. Both physicians are staff members of the Providence Veterans Administration Hospital.

sclerae were moderately icteric. Temperature, pulse, respiratory rate, and blood pressure were normal. No lymphadenopathy was present. An old appendectomy scar was present in the right lower quadrant. The spleen was not palpable. The liver was enlarged, its edge being felt one fingerbreadth below the right costal margin. There was slight tenderness in the right hypochondrium and in the epigastrium. Brown feces soiled the glove used for rectal examination. The patient complained of generalized pruritus.

Laboratory Data: Blood Kahn test was negative. Urinalyses showed bile and a trace of albumin on two occasions. Serum amylase was 80 Somogyi units. Prothrombin times varied between 68 and 81 per cent of normal. Two blood sugar determinations were 84 mg. % and 97 mg. %, respectively. Three stool specimens were negative for ova and parasites. The bleeding and clotting times were normal. The results of blood counts and liver function tests are listed in Table I and Table II.

X-ray Data: Routine chest X ray was negative. Films of the skull and cervical spine, intravenous pyelogram, upper gastrointestinal series and barium enema revealed no abnormalities. The gall bladder was not visualized following oral Priodax[R] on October 26, or the intravenous administration of Cholegrafin[R] on October 28. A subsequent cholecystogram with Priodax[R] on November 24 showed a normally filling gall bladder without evidence of calculi.

Hospital Course: For three days after admission symptoms persisted unchanged and jaundice increased. There was no fever. Bowels were regular and the stools were a light brown. Laboratory tests confirmed the increase in jaundice noted clinically and indicated that it was obstructive in type. Treatment was symptomatic.

TABLE I

Blood Counts

Date	*Hemoglobin* Gm. 100 cc.	*White Blood Count*	*Differential Per Cent*
10-18	15.5	8,800	P 78 L 20 M 2
10-20	15.9	14,000	P 71 L 15 E 4 M 3 B 2
11-4	14.0	9,900	Not done

On the fourth hospital day there occurred a marked accentuation of abdominal pain. Anorexia continued and there was nausea without emesis. Examination of the abdomen revealed an accompanying increase in local tenderness in the right upper quadrant and muscle guarding, which had been absent previously. On the following two days the abdominal signs were unabated and several observers described a possible tender palpable mass in the right upper abdomen opposite the ninth costal cartilage. The white count had risen to 14,000. During this period, and throughout the remainder of the hospital stay, his temperature remained normal.

As a result of this recrudescence of symptoms and the alarming nature of the abdominal findings, the consensus of opinion was that this patient was

TABLE II

Liver Function Tests

Date	*Serum Bilirubin* mg. %	*Total Cholesterol* mg. %	*Cholesterol Esters* % of Total	*Thymol Turbidity Units*	*Alkaline Phosphatase Bodansky Units*	*Cephalin Flocculation* 48 hrs.	*Protein* Gm./100 cc.
10-8	8.1	290	52	3.0	6.4	2+	Total 7.6 Alb. 4.8 Glob. 2.8
10-25	5.7	314	69	2.0	3.8	2+	—
10-28	3.9	—	—	—	—	—	—
11-14	1.9	—	—	3.0	—	—	—
11-22	0.6	267	65	2.0	—	Neg.	Total 7.1 Alb. 5.2 Glob. 1.9

suffering from extrahepatic jaundice most probably due to acute cholecystitis with obstruction of the common duct from adjacent inflammation or calculus. Serious consideration was given to exploratory laparotomy, but the decision to operate was delayed because of the history of chlorpromazine administration and the recognition of jaundice as a possible sequel to this. During the period of delay, after the third day of exacerbation, the intensity of symptoms began to subside as did the abdominal signs. With the disappearance of muscle spasm, no abdominal mass could be made out. From this point on, gradual but progressive improvement took place until, after the third week of hospitalization, the patient was asymptomatic and jaundice was no longer apparent clinically, although the serum bilirubin was still slightly elevated.

On November 2, about the 23d day of illness and the 17th hospital day, needle biopsy of the liver was performed. The pathologist reported, "Sections of liver show strands of lymphocytes from the central vein. Overall architecture appears normal. Moderate brown pigment is noted through the liver. Sinusoids are thin. One focus shows liver cells have disappeared and are replaced by empty spaces or by fibroblasts, lymphocytes, polys and eosinophiles. There are an unusual number of bile plugs in the canaliculi. Diagnosis: 1. Jaundice, liver; 2. Cholangitis, mild."

After the patient had achieved complete clinical recovery and serum bilirubin values had returned to normal, a repeat cholecystogram demonstrated a well visualized gall bladder without stones.

The pattern of this man's illness and the failure to elicit a history of exposure to any other etiologic agent, together with the supporting evidence of radiological studies, serial liver function tests, and liver biopsy verified the diagnosis of jaundice due to a toxic cholangiolytic hepatitis caused by chlorpromazine.

Discussion

The incidence of jaundice in reported series of chlorpromazine treated patients has been variable, but generally low.[1, 4, 6-10] In those patients in whom this complication has been observed, the condition has usually run a benign course, the jaundice subsiding spontaneously in some two to three weeks after discontinuance of the drug.[1, 4-10] In a few of these patients chlorpromazine therapy has been reinstituted without the further development of jaundice or changes in liver function tests.[8] Chlorpromazine has been administered to persons with pre-existing liver disease without deleterious effects. One death from severe toxic hepatitis presumably due to this drug has been reported.[7]

Review of previous reports[2-10] reveals that the jaundice produced by chlorpromazine is often associated with grippe-like symptoms, abdominal discomfort or pain, anorexia, nausea, vomiting, and low grade fever. These symptoms may precede the onset of jaundice by a few days. Tenderness in the epigastrium and right upper quadrant, with or without slight hepatomegaly, may be found. The peripheral blood at times shows a leukocytosis with an increase in the eosinophiles. Annoying pruritus is frequently present. Urine becomes dark and the stools may become clay colored. Liver function studies are as a rule typically those observed in obstructive jaundice. There is elevation of the serum bilirubin, the alkaline phosphatase, and the serum cholesterol. The flocculation tests are normal and there is no alteration of the A G ratio or cholesterol esters. Liver biopsy shows varying degrees of inflammatory reaction. Infiltrations consist of polymorphonuclear leukocytes, lymphocytes, and occasionally eosinophiles. Bile is found plugging the canaliculi.

Why such cases should closely resemble obstructive jaundice due to other causes is readily apparent. That real difficulties in differential diagnosis do arise is illustrated by the fact that some patients with chlorpromazine-induced jaundice have been subjected to laparotomy.[2, 3] In the case reported here, operation was contemplated.

An awareness of the ability of chlorpromazine to exert toxic effects on the liver in some patients and a familiarity with the fairly characteristic syndrome of obstructive jaundice produced will lead to more accurate diagnosis and the avoidance of needless surgery.

SUMMARY

A case of chlorpromazine-produced jaundice which simulated extrahepatic biliary obstruction is presented.

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THE USE AND ABUSE OF HORMONES

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CONCLUSION

In conclusion then, I want to repeat that there are major strides being made in the preparation and synthesis of new hormonal preparations every day. It is inconceivable that most of us can keep up with the differences in pharmacology and physiologic results from all of these. It is best that we familiarize ourselves with some good preparation and know how to use it and what its results will be, and that we insist that patients under such therapy check in with us frequently enough so that they do not get out of control or begin to show alarming side reactions without our knowledge. These substances should be used only when indicated for definite reasons; their use should be curtailed by knowledge of possible side effects, one should always be cognizant of the fact that most of them cause a physiologic suppression of the stimulating agent, usually the pituitary gland, and we should be constantly aware of the fact that their misuse can cause unwarranted damage to the organism. There are many and devious new ways of using these potent agents that are now being tested clinically. I feel that these new indications will have to be proven by the test of time. Those who are fortunate to have endocrine laboratories and research facilities available to keep track of the responses called forth by hormone therapy are fortunate in their position as pioneers in the field. Others, however, will have the often more satisfactory reward of using these drugs in safe and sure measure without courting the deleterious possibilities of their misuse.

A REAPPRAISAL OF MEDICO-ECONOMIC PROBLEMS

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catalogues and *disavow* their current textbooks which *expound* the osteopathic concept?

Should the several state and county medical societies be free to interpret the principles of medical ethics to suit their own convenience or should the Judicial council interpret for all?

These questions require serious consideration.

15. *United Nations and National Legislation*

The charter of the United Nations is due for revision very soon. Powerful forces will be at work. It is imperative, therefore, that we as members of the medical profession be aware of the activities of the various agencies of the United Nations. The International Labor Organization and the World Health Organization merit special attention. *Why?*

Because socialized medicine is not a dead issue with the I.L.O. Issues which we have been able to defeat nationally may still threaten us internationally.

What about the Bricker amendment? Though the American Medical Association supported it when it was introduced, I have heard much adverse criticism from doctors who, though poorly informed on the issues, were ready to take an opposite stand.

It would be exceedingly fortuitous for the House of Delegates of the A.M.A. and its board of trustees to know that their attitude, as result of intensive study and careful consideration of all factors involved, has the intelligent and whole-hearted support of an informed profession behind them.

Unless every physician becomes fully informed, and equipped with enough background to reach a clear decision on these issues, our efforts and our abilities are wasted.

A former secretary of this conference once said to me, "If the doctors were briefed one-tenth as much with such issues as government problems as they are with scientific matters, they would wield a terrific influence."

The American medical profession is well and ably represented at the national level. Attendance at the meetings of the House of Delegates is about one hundred per cent at every session. The reference committee meetings really thrash out their problems; but far too often this sincerity of purpose, this appreciation of all facets of medical care, does not extend down the line to the place where it is needed most—the grass roots.

I urge, in conclusion, therefore, that all state societies take the initiative in formulating committees to consider the various problems affecting medicine; and, in turn, promote the study and analysis of these problems. Development of similar study groups at the county level should follow so that all in medicine will be conversant with the problems affecting it. Only by this method can the profession most effectively serve our patients, our community and our country.

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VETERANS' BENEFITS

THE THOUGHT provoking series of articles on veterans benefits published by the PROVIDENCE EVENING BULLETIN have been reviewed by the Committee on Veterans Affairs of the Rhode Island Medical Society which has been particularly concerned with the ever-expanding hospitalization and medical care program of the Veterans Administration as it affects the future of our state, municipal and private institutions.

The reports of the EVENING BULLETIN substantiate the outstanding investigative commission reports that have been made before Congressional committees in recent months. They re-emphasize the dangers inherent in the uncontrolled spending program of the Veterans Administration which have been pointed out on past occasions by our society and the American Medical Association.

The basic fault, as we view it, lies with the Congress, not with the Veterans Administration. The EVENING BULLETIN articles focus attention on the impact that the action of Congress has upon every taxpayer. Certainly the Rhode Island members in Congress should be asked by every public spirited citizen to give the problem the serious attention it warrants with careful concern for the future of hospitalization and medical care in our state and in our nation.

The great majority of the membership of the Rhode Island Medical Society are veterans who have seen active duty in one or more wars. Therefore we speak as veterans as well as citizens when we ask for an appraisal of the veterans hospitalization and medical care program devoid of emotional bias or prejudice. As physicians we would make our position clear. We do not seek any limitation or impairment whatever of the medical care program now available to veterans who have become physically handicapped as the result of active military duty.

We maintain that veterans with peacetime or wartime service whose disabilities or diseases are *service incurred* or aggravated, should receive complete and comprehensive care. We feel that within the limits of existing facilities care should be extended to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of *non-service connected* origin, if such veterans are unable to defray the expenses of the necessary hospitalization in local institutions. We recognize the long-term stay that can be necessary for recuperation from such illnesses. We believe that the care should be given in our local public and private sanatoria and hospitals whenever possible, and that the people of Rhode Island have a primary

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responsibility to provide such services for those unable to pay for them.

Our committee met with representatives of veterans organizations in Rhode Island on a previous occasion to discuss this serious question, and urged that they take leadership in controlling the situation that has been set forth in such detail by the Evening Bulletin in its reports. We feel, as all thoughtful citizens ultimately must, that preferential treatment for veterans with non-service-connected disabilities cannot be continued indefinitely in view of the detrimental effect on the health and economy of the entire nation. When the possible or probable financial burden of the near future is estimated by taking into account the increased number of veterans as the result of the tremendous size of our Armed Forces in World War II, and the additional number of Korean veterans, the magnitude of the problem is readily apparent.

We have noted with interest the Evening Bulletin's analysis of the effect of the inability to pay declaration for veterans applying for care at the VA hospitals. In December, 1953, the Rhode Island Medical Journal, speaking for the society, stated editorially that

> "The addendum is a step in the right direction toward more efficient management and use of the services that the people of this country have indicated that they wish to provide for veterans who truly cannot meet the cost of hospitalization or medical care. . . .
>
> "But since no investigation of such cases will be made at the local level, an addendum loses much of its effectiveness. . . . The medical profession of this country has been outspoken in what it considers the real problem regarding veterans' medical care and the recent addendum does not resolve the basic issue. . . ."

Our position will be opposed by those who place selfish interest above the good of all the people, but our action, initiated almost two years ago, was the result of concern for *all* citizens and their national welfare. We can only hope that the factual stories of the Evening Bulletin will awaken a desire in everyone to seek the best for the war-injured veteran, and to act to control the use of the services by those whose ailments in later years are in no manner traceable to military service.

Committee on Veterans Affairs

CANCER CHEMOTHERAPY

We have just received notice that the Cancer Chemotherapy National Committee is starting a big program of research into the subject of the use of drugs for the treatment of cancer. They have got together a most impressive group of able men and large societies and the chairman is Doctor Sidney Farber of the Children's Center in Boston. We have heard Doctor Farber speak here in Providence on this subject when he has presented some striking cases of cancer in children treated by drugs.

Probably a good many of us would be skeptical about the cancer problem being solved by the use of drugs, but what does our skepticism amount to here? Practically nothing is known definitely about the cure of cancer. Every lead must be followed up and it is a pleasure to know that this particular lead is being followed up by such a large representative and reliable group as this one is.

THE OSTEOPATHIC ISSUE

The House of Delegates of the American Medical Association gave liberally of its time at the Atlantic City meeting to discuss the report of the committee for the study of relations between osteopathy and medicine, which climaxed its work with a first-hand summary of its findings as the result of personal visits to five of the six osteopathic schools of the nation. No explanation was given as to why the Philadelphia School, reportedly one of the largest, would not consent to inspection by the committee.

Our Doctor Charles L. Farrell, addressing the Conference of Presidents and Other Officers of State Medical Associations on the day prior to the opening of the AMA session, undoubtedly pinpointed the major flaw in the entire osteopathic study report when he posed the question that "if osteopathy has discovered that the osteopathic lesion does not now and never did exist, should not the House of Delegates of the Osteopathic Associate promulgate this fact and not the House of Delegates of the A.M.A.?"

In its final session the A.M.A. delegates received the study committee report, discontinued the committee, and voted that "if and when the House of Delegates of the American Osteopathic Association, their official policy-making body, may voluntarily abandon the commonly so-called 'osteopathic concept,' with proper deletion of said 'osteopathic concept' from catalogs of their colleges; and may approach the trustees of the American Medical Association with a request for further discussion of the relation of osteopathy and medicine, then the said trustees shall appoint another special committee for such discussion."

A singular touch to the controversial issue as discussed by the delegates was the concluding quotation from the oath of Hippocrates used by Doctor Milford O. Rouse of Dallas, Texas, member of the reference committee on Medical Education and Hospitals, who signed the report adopted by the House:

". . . and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the Art to my own sons and to those of my teachers,

and to disciples bound by the stipulation and oath, *according to the law of medicine, but to none others.*"

ETHICAL PRINCIPLES

Much has been written and spoken in recent years of the issue of ethics in the professional fields, and particularly medical ethics.

We fear that the public, and even many physicians, think of the principles of medical ethics as immutable laws that allow for no interpretation by reliable authorities, nor any amendment.

Actually the principles of ethics to which the physician subscribes are intended to serve merely as a guide as he strives to accomplish his prime purpose of serving the common good and improving the health of mankind. The principles help solve many of the otherwise complex problems that arise in the daily relationships of the physician and his patient, the physician and his colleagues, and the physician and the general public.

The physicians themselves have given an excellent example of the impossibility of casting the principles as immutable laws by their decision to amend Section 8 relative to the dispensing of drugs and appliances. Possibly because of violation of the principle in one area, the House of Delegates of the American Medical Association amended the section at its session in Miami last December to provide that it would be unethical "for a physician to participate in the ownership of a drugstore in his medical practice area unless adequate drugstore facilities are otherwise unavailable" and this inadequacy must "be confirmed by his component medical society." Further, the same principle was made to apply to physicians who dispense drugs or appliances.

The idea behind the amendment was basically sound in that it aimed to prevent a physician from ever exploiting the patient by selling remedies or appliances. But to correct a local problem in one area of the country the principle was amended without sufficient thought to the other areas wholly dependent upon the physician for these services. As subsequent events showed in the past six months, doctors who adhered to the new regulation penalized their patients.

In rural and suburban areas patients could not always get to a drugstore, and even in cities the stores are not open at night when remedies would be required by the physician. In the far reaches of the country removed from metropolitan services the physicians have for years had to assist patients with appliances ranging from eye glasses to arch supports for shoes.

Little wonder then that the House of Delegates of the A.M.A., meeting in Atlantic City last month, rewrote to the principle to aid and protect the patient, and to guide the physician properly. The new amendment achieves the desired result in simpler language, as follows:

"It is not unethical for a physician to prescribe or supply drugs, remedies, or appliances as long as there is no exploitation of the patient."

TELEVISION PROGRAM— A.M.A. CLINICAL SESSION

Physicians of New England are showing a most gratifying spirit of cooperation in the early planning for the Clinical Session of the American Medical Association to be held in Mechanics Building, Boston, for the four days from November 29 to December 2, 1955.

One feature of the session will be the television programs (in color) which will be possible through the generosity of Smith, Kline and French Laboratories of Philadelphia.

Television programs will originate from the New England Deaconess Hospital and sent by closed circuit to a special hall in Mechanics Building. The morning programs will be *surgical* in nature and demonstrate operations by surgeons on the staff of the Deaconess. The afternoon programs will consist of talks, demonstrations and panel discussions on *medical* subjects.

Participation in the afternoon medical programs is open to all, subject to acceptance by the Committee. Physicians desiring to take part are urged to send in abstracts promptly, summarizing the proposed presentation in not more than 300 words. In addition, ideas or suggestions for appropriate topics and participants in either the surgical or medical programs will be welcomed by the Committee. Prospective participants should keep in mind that a successful television demonstration *must* have visual interest. One must avoid reading a paper before the camera and the presentation should be built around patients, instruments, apparatus, charts, slides and x-rays. There will be no facilities for showing films or movies. Participants will be given information on television appearance and on size and color of charts and slides at a special orientation meeting which will be held 6-8 weeks prior to the meeting.

Proposals and suggestions should be sent to the Chairman of the Television Committee, Alexander Marble, M.D., 81 Bay State Road, Boston 15, Mass.

Sincerely yours,

C. Cabell Bailey, M.D.
Alexander Marble, M.D.
Kenneth W. Warren, M.D.

81 Bay State Road
Boston 15, Mass.

SPECIAL NURSING FEES

At a recent meeting of the Board of Directors of the Rhode Island State Nurses' Association the recommendation was made by the Private Duty Nurses' Section for a two dollar increase in the present salary schedule for major lung and cardiac surgery.

Effective immediately the salary schedule for major lung and cardiac surgery is $14 for an eight-hour day. This rate is recommended for state-wide adoption in Rhode Island.

R. I. STATE NURSES' ASSOCIATION

THE DOCTOR IN COURT

Opinion of Legal Counsel of the Society on Testimony Regarding the Mental Health of a Patient

A DOCTOR is often confronted with a request for information as to the mental health of a patient. He may be asked for an off-the-record statement, or to make a formal statement or to testify in court. Such an inquiry may come from a variety of sources and may be either general in scope or pertain to a particular situation, such as the patient's capacity to make a will. The circumstances and extent to which a doctor may decide to accede to such a request and volunteer information is a matter of his own personal decision under the circumstances of each case. Assuming that he has declined to accede to the request, the question arises whether he can be compelled in this state to make a statement or testify and, if so, to what extent. This question is discussed in this article.

A doctor, like any other person, is obliged to answer a subpoena served upon him. In Rhode Island no special immunity exists which exempts a doctor from testifying. He can be compelled to testify or make a deposition about all relevant matters of fact within his personal knowledge and observation.

He may be called as an *ordinary* witness to testify as to matters having nothing to do with his profession, as, for example, his knowledge, observation and recollection of an automobile accident witnessed by him. He may also be called as a *professional* or *technical* witness where his testimony relates to his examination, treatment or medical observations of a patient. He may also be called as an *expert* witness to give opinion evidence based upon his professional knowledge, skill or experience based either upon his treatment of a patient or to answer hypothetical questions.

Thus, a doctor who witnessed an automobile accident may be compelled to testify to the facts observed by him, such as the speed and direction of the cars, to any facts observed by him relating to injuries to the persons involved in the accident and other facts obtained through examination or treatment of such persons.

A question is frequently raised as to whether a doctor is "privileged" to refuse to disclose confidential communications received from a patient in the course of treatment. Many states, both by statute and by court decisions, have recognized the confidential relationship between a doctor and his patient and have permitted doctors to maintain inviolate the statements communicated to them by their patients or learned from observation or examination of or conversation with their patients. The right to invoke this privilege, however, is one that may be waived by the patient.

Rhode Island, however, does not recognize the existence of such a doctrine of privileged or confidential communications between physician and patient. The Rhode Island Supreme Court has laid down the rule that confidential communications made to a physician are not privileged so as to protect the physician from divulging them as a witness when called upon to do so as a witness in court.

Banigan v. *Banigan*, 26 R.I. 454 (1904);
Remington v. *Rhode Island Company*,
37 R.I. 393 (1915).

A doctor who is subpoenaed as an *ordinary witness* or as a professional or technical witness may be required to testify to facts concerning his patient without any further compensation than the ordinary witness fees paid for attendance in court.

A doctor who is called as an *expert witness* may be asked to testify by giving an opinion based upon his ability to draw inferences and conclusions from his observation of the facts or the facts as presented to him in a hypothetical question.

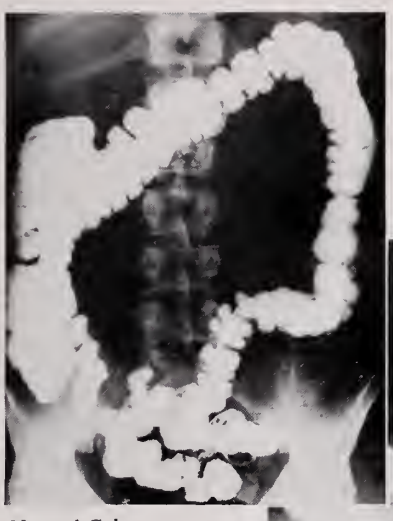
The legal authorities are divided on the question as to whether an expert witness can be compelled to testify to his conclusions unless he is paid an expert witness fee. One view taken by certain legal authorities is that a doctor's expert opinions are his private property that he should not be deprived of without just compensation. A contrary view is taken by many legal authorities which state that an expert witness stands the same as any other witness and may be compelled to testify without being paid expressly for a professional opinion. In the absence of any decision by the Rhode Island courts on this question we cannot accurately predict which of these views the Rhode Island Supreme court will adopt.

It is generally agreed by the legal authorities, however, that an expert cannot be required to make special examinations of or engage in experiments or undertake any other operations requiring professional skill and training unless he is paid or tendered additional compensation for such activity.

The principles set forth above are applicable whether the information requested is oral or written or is contained in records and reports of the doctor subpoenaed as a witness.

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Normal Colon



Ulcerative Colitis



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Smoothage in Correction of Colon Stasis

To initiate the normal defecation reflex, the "smoothage" and bulk of Metamucil provide the needed gentle rectal distention.

Once the habit of constipation has been established, due to any of a large number of causes, it becomes a major problem. Self-medication with irritant or chemical laxatives, or repeated enemas, usually causes a decreased, sluggish defecation reflex and may result in its complete loss.

Rectal distention is a vital factor in initiating the normal defecation reflex, and sufficient bulk is thus of obvious importance in restoring this reflex. Metamucil provides this bulk in the form of a smooth, nonirritating, soft, hydrophilic colloid which gently distends the rectum and initiates the desire to evacuate. Metamucil demands extra fluid, imparting even greater smoothage to the intestinal contents.

It is indicated in chronic constipation of various types—including distal colon stasis of the "irritable colon" syndrome, the atonic colon following abdominal operations, repressions of defecation after anorectal surgery and in special conditions such as the management of a permanent ileostomy. Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is supplied in containers of 4, 8 and 16 ounces. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

SEARLE

ANNUAL REPORTS — 1955

THE RHODE ISLAND MEDICAL SOCIETY

ANNUAL REPORT OF THE TREASURER

Financial Report, 1954

SUMMARY

Cash balance, Checking Account, Industrial National Bank, January 1, 1954	$ 2,240.83
Receipts, 1954	40,136.76
Total	$42,377.59
Expenses, 1954	39,515.60
Cash balance, Checking Account, Industrial National Bank, January 1, 1955	$ 2,861.99
Cash balance, Checking Account, credited to Special Funds of the Society, January 1, 1955	622.65
Cash balance, Checking Account, Industrial National Bank, for Operating Expenses, January 1, 1955	2,239.34

* * *

Total Cash and Invested Assets, January 1, 1955:

Cash balance, checking account, Industrial National Bank	2,861.99
Investments, Pooled Funds, Trust Department, Industrial National Bank Agent	
Total book value	32,099.92
Cash balance to be invested	1,831.87
Total	$36,793.78

JOHN A. DILLON, M.D., *Treasurer*

CHILD AND SCHOOL HEALTH COMMITTEE

The following is a report of the work of this committee during this period:

Communications received from Dr. James Hanley, Superintendent of Schools, Providence, and from Dr. Michael Walsh, State Director of Education, in regard to the expectations of the school physician, were presented to the members of the committee, and were discussed.

A report of the periodic scheduled medical examinations of school children, with particular concern of the relative roles of the family and school physician was presented. This report stressed the primary role of the family physician as the medical examiner of the children, and the medical examination by the physicians serving the schools being limited to those pupils not being regularly subjected to medical examinations by the family physician. Such examinations are recommended every three years of school life.

It was further recommended that suitable forms be made available to the superintendents of schools of cities and towns of the state, for distribution to the pupils, at the beginning of the school term; stressing the primary obligations to the parents, for this examination through their family physician. This was noted to be in keeping with the trend throughout the country in handling the school examinations.

Reports from various sections showed the varying response to this development ranging from a 20% response to family physicians in Hartford, Connecticut, to a 90% response in Evanston, Illinois.

Mr. George Kenny was instructed to set up a form for the further evaluation of the plan, by the school physician.

This policy was adopted because of the realization of the impossibility of the school physician to adequately perform his role with the time available to him and the number of pupils that have to be examined.

Communications from other states on the handling of funds in relations to school health services were discussed. Very little pertinent information was to be found in these communications.

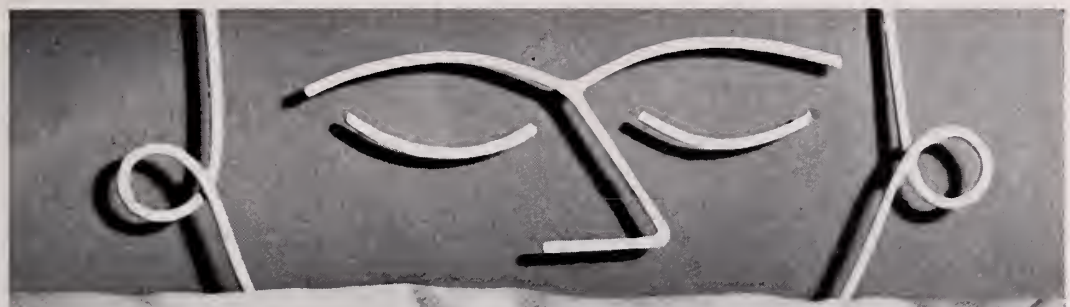
It was recommended by the school health physicians to refer all patients with defects to their family physician, rather than directly to any special group.

On March 7, 1955, a meeting was held with the Exeter School Parent Teachers Association and our committee. Suggestions pertaining to the improvement of conditions of the retarded children at Exeter was reviewed by the committee and a sub-committee was formed to review these suggestions. Maurice Laufer, M.D., was appointed chairman of the sub-committee with Dr. John Farley and Dr. John Barrett, as additional members. A report from this committee will be forthcoming at a later date.

The committee received a communication from the Rhode Island Society for Crippled Children

continued on page 402

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Rapid onset—15-20 minutes
Lasts 4-8 hours
No hangover

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Scored 0.25- and 0.5-Gm. tablets.

C I B A Summit, N. J.

2/2075M

CHILD AND SCHOOL HEALTH COMMITTEE

continued from page 400

and Adults, regarding the expansion of diagnostic and therapeutic services dealing with the unusual child, with the approval of the Rhode Island Medical Society.

There will be a luncheon meeting with the Executive Director, Mrs. John Langdon, on Wednesday, April 13, 1955, to discuss these proposals. A report will be made at a later date.

We regret very much that we have not been able to meet with Mr. John Yale Crouter, principal of Rhode Island School for the Deaf, who has asked for a hearing with representatives of the medical society. There have been too many considerations to properly complete all during this year. It will be kept in mind for a future meeting.

Dr. Donald Dukelow of the American Medical Association, appeared and spoke at a meeting on school health policies on April 4, 1955.

Dr. Roswell Gallagher of the Children's Hospital, Boston, will be a guest speaker at our annual meeting on May 4, 1955. His subject will be "The Adolescent's Personality."

WILLIAM P. SHIELDS, M.D., *Chairman*

DIABETES

The Diabetes Detection Drive was held the week of November 14 to 20, 1954. 11,080 urine tests were done throughout the state. A breakdown of this is as follows:

Private physicians 1,563; Providence and Newport Diabetes Fairs 211; Hospitals 35; Industrial Clinics 3,129; Schools 4,169; Rhode Island Pharmaceutical Association 1,774; Private Laboratories 24; District Nurses 175.

Of the 11,080 urines checked, 136 were reported as positive. All were referred to their private physicians, and the last report was that 34 new diabetics were diagnosed. Blood sugar tests were done by the Clinitron method at the Diabetes Fairs. In Providence, 495 tests were taken; 35 were positive. In Newport, under the direction of Dr. Edward Zamil, 271 tests were taken and 33 were positive. Out of the 68 positive findings, 32 were known diabetics, and 36 new cases were discovered.

We received Clinitest and Galatest, 10,000 of each, free of charge; 5,000 of each were used and the remainder returned. 21,000 St. Louis Dreypak were distributed and 9,072 were returned and processed by Mr. William Hagan of the Rhode Island Department of Health.

Both Providence and Newport had a Diabetes Fair. These Fairs were held one day. Members of the Committee on Diabetes were present. Free blood and urine tests were done; there were movies on Diabetes, with question and answer periods; meal planning instruction, and several other exhibits were presented. At the Providence Fair, the Women's Auxiliary, under the direction of Mrs. Irving A. Beck, assembled 20,000 Dreypaks for the schools and industrial plants. They also assembled cartons with pamphlets, posters, clinitest and other material, and helped to distribute these to the various industrial plants. On the day of the Fair, the Women's Auxiliary members staffed the registration booth, checked registrants at the Clinitron, assisted in recording results of tests of blood and urine specimens and served as guides. A new feature of the Fair this year, was the "Lay Society Booth," manned by Social Service under the direction of Miss Bess Medary and Miss Alice M. Knott, where questionnaires were filled in by persons interested in organizing a Rhode Island Diabetes Lay Society. We are very grateful to Mr. W. Connell for permitting us to use the office of the Department of Employment Security for our Diabetes Fair.

The following is an excerpt from a letter received from Fred W. Morse, Jr., M.D., Program Consultant, U.S. Public Health Service: "I was so glad I had an opportunity to come to the Diabetes Fair in Providence two weeks ago and see the enthusiastic way in which the Providence Physicians and the State Department of Health are making this fine service available to the public. Health officers would never get anything done in the way of a diabetes program if it were not for such private physicians."

Participants in the Diabetes Detection Drive were: Rhode Island Medical Society; Auxiliary of the Rhode Island Medical Society; Association of Clinical Laboratories; Rhode Island Restaurant Association; Rhode Island Department of Education; Rhode Island Chiropody Association; Rhode Island Pharmaceutical Association; Rhode Island League of Nursing Education; Rhode Island State Organization for Public Health Nursing; Rhode Island Social Workers; and from the Rhode Island Department of Health: industrial nurses, public

continued on page 404

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ALL PATIENTS QUIETED

They "soon became quiet and dropped into light sleep yet could be easily awakened to receive medication or nourishment."

NURSING CARE SIMPLIFIED

"The patients were more amenable to suggestions from the nursing and medical staff, there were fewer falls from bed."

FOOD RETAINED EARLIER

Nausea and vomiting were stopped, and the patients "were able to retain solid food 18 to 24 hours earlier than the barbital treated group."

SHORTER HOSPITAL STAY

Patients "were in condition to be discharged from the hospital on an average of 24 hours earlier" than those treated with barbiturates.

1. Mitchell, E. H.: Chlorpromazine in the Treatment of Acute Alcoholism, Am. J. M. Sc. *229*:363 (April) 1955.

'Thorazine' Hydrochloride is available in 10 mg., 25 mg., 50 mg. and 100 mg. tablets; 25 mg. (1 cc.) and 50 mg. (2 cc.) ampuls; and syrup (10 mg./5 cc.).

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*T.M. Reg. U.S. Pat. Off. for S.K.F.'s brand of chlorpromazine.

DIABETES REPORT

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health nurses, laboratory aid health education, nutrition service, adult heart disease control. All our publicity was handled by local newspapers, radio and television stations.

The committee wishes to express its sincere thanks to Mr. John E. Farrell, Executive Secretary, Rhode Island Medical Society. Mr. Farrell makes himself available at all times and gives generously of his time and experience; Dr. Edward McLaughlin, Director of the Department of Health, and Mr. George Kenny, of the Health Education Division, for organizing the workers from the Rhode Island Department of Health; and Mrs. Irving A. Beck, who gave up so much of her time in preparing a program for the Women's Auxiliary of the Rhode Island Medical Society. We wish also to thank the PROVIDENCE JOURNAL-BULLETIN for writing an editorial on our drive, and also for the publicity they gave us. Our thanks and appreciation to all the following, for without each and everyone of them, our drive could not have been a success. Dr. Amy Russell certainly deserves special commendation for the excellent job she did in the East Providence schools.

LOUIS I. KRAMER, M.D., *Chairman*

The following industrial plants and nurses participated in the Diabetes Detection Campaign: Mrs. Dorothy Hoadley, R.N., Abrasive Machine Tool Co.; Mrs. Doris Quigley, R.N., American Silk Spinning Co.; Mrs. Lisa Staab, R.N., Apponaug Company; Mrs. Anna Goss, R.N., Boston Store; Mrs. Thelma Brasse, R.N., Bulova Watch Co.; Mrs. Marion Parker, R.N., Corning Glass Works; Miss Gladys Champlin, R.N., Coro, Inc.; Mrs. Dorothy Finucane, R.N., Crescent Co.; Miss Ida Costello, R.N., Fruit of the Loom; Miss Simone Cadoret, R.N., Glenlyon Print Works; Mrs. Anita Lomas, R.N., Wm. H. Haskell Co.; Miss Doris Duffy, R.N., Imperial Knife Co.; Mrs. Eliza Hayward, R.N., Lymansville Co.; Miss Mary Bayley, R.N., American Insulated Wire Co.; Miss Ann Doonan, R.N., American Textile Co.; Mrs. Evelyn Heuberger, R.N., Sidney Blumenthal & Co.; Mrs. Marjorie Dennis, R.N., Bristol Mfg. Co.; Mrs. Marion Stewart, R.N., Chandler-Evans Co.; Miss Ruth Estee, R.N., Coats & Clark; Mrs. Ethel Murphy, R.N., Cranston Print Works; Mrs. Katherine Curry, R.N., Davol Rubber Co.; Mrs. Muriel Gosselin, R.N., Genser Mfg. Co.; Mrs. Phyllis Taylor, R.N., Grinnell Corp.; Miss Ruth Hellman, R.N., Hemphill Company; Mrs. Emma Spooner, R.N., Kennecott Wire & Cable Co.; Miss Ella Lisi, R.N., Walter Marshall Spinning Co.; Miss Virginia Dunphy, R.N., Monowatt Corp.; Mrs. Agnes Crawford, R.N., Newman-Crosby Steel Corp.; Miss Lillian Atkinson, R.N., Outlet Company; Mrs. Olga Adler, R.N., Providence Washington Insurance Co.; Mrs. Virginia Baltzell, R.N., Royal Electric Company; Miss Rita Boffi, R.N., Uncas Mfg. Co.; Mrs. Mary Benson, R.N., United States Rubber Co.; Miss Ellen O'Neill, R.N., United States Rubber Co.; Mrs. Genevieve Peckenham, R.N., Universal Winding Co.; Mrs. Elinor Clauss, R.N., Socony-Vacuum Oil Co., Inc.; Mrs. Jean Townsend, R.N., George C. Moore Co.; Miss Eleanor Fulton, R.N., Nicholson File Company; Mrs. Gertrude White, R.N., Potter & Johnston Machine Co.; Miss Eleanor Conley, R.N., R. I. Hospital Trust Co.; Mrs. Mildred Shellenberger, R.N., Royal Electric Company; Mrs. Catherine McAuliffe, R.N., Steere Mill; Mrs. Hope Pierce, R.N., Surgical Clinic; Mrs. Dorothy Heron, R.N., United States Rubber Co.; Mrs. Mary Turo, R.N., Wanskuck Co., and Mrs. Rita Young, R.N., Union Wadding Co.

The following members of the Women's Auxiliary of the Rhode Island Medical Society assembled Dreypaks and assisted at the Diabetes Fair by registering guests and acting as guides: Mrs. Vincent Zecchino, Mrs. Guy Wells, Mrs. Manuel Horwitz, Mrs. C. W. Cashman, Jr., Mrs. George Bowles, Mrs. William Hindle, Mrs. E. Damarjian, Mrs. Joseph Johnston, Mrs. Stanley D. Davies, Mrs. Russell Hager, Mrs. Eric Denhoff, Mrs. A. Archetto, Mrs. C. F. Gormly, Mrs. C. Ashworth, Mrs. Earl Cohen, Mrs. Maurice Silver, Mrs. Francis E. Temple, Mrs. Walter Dufresne, Mrs. M. Yessian, Mrs. F. A. Webster, Mrs. F. Temple, Mrs. D. Freedman, Mrs. John Gilman, Mrs. B. H. Buxton, Jr., Mrs. Nathan Chaset, Mrs. Frank B. Cutts, Mrs. William Leet, Mrs. F. Fratantuono, Mrs. Arthur Dell, Mrs. Robert V. Lewis, Mrs. John Ferris, Mrs. A. O'Dea, Mrs. R. Haverly, Mrs. A. E. Geremia, Mrs. Earl Kelly, Mrs. Jacob Stone, Mrs. Harry Triedman, Mrs. Carroll M. Silver, Mrs. Raymond Trott, Mrs. Henry Utter, Mrs. Joseph Franklin, Mrs. John Gilman, Mrs. Leonard Sutton and Mrs. Irving Beck.

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CLINICAL DATA ON REQUEST

*Combes, F. C. & Canizares, O.: New York St. J. Med. 52:706, 1952; Marsh, W. C.: U. S. Armed Forces M. J. 1:1045, 1950.

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DIABETES REPORT

continued from page 404

Pharmacists: Victor Canaipi, Butler Hospital; Herbert Collins, Dolan's Drug Store; Maurice Genter; Edward Gilberti, Chief Pharmacist, State Institutions, Howard; and Professor Edward M. Altman.

Medical representatives: Steve Scafarella, E. R. Squibb Co.; C. F. Brady, Sharpe and Dohme; Charles McManus, Eli Lilly & Co.; Floyd Porter, O. Becton Dickenson & Co., and A. P. Genovese, Ames Company.

Students from the Rhode Island College of Pharmacy: Regent Degagne, Martha Caffey, Rita DelFino, Ronald Gautieri, Alfred Brodeur, Andrew Prythe, Joseph Anthony and Philip Levine.

Nurses: Mrs. Georgia Macrae, R.N.; Miss Antonetta Carlo, R.N.; Miss Claudette Bouvier, R.N.; Rasaline McGehearty, R.N.; Bertha Mugurdichian, R.N.; Elizabeth Tighe, R.N.; Carla DePrizio (student nurse); Mrs. Louise Thibadeau, R.N.; Miss Priscilla Lees, R.N.; Miss Irene Burdge, R.N.; Virginia Doyle, R.N.; Doris Genereux, R.N.; Marguerite Blais (student nurse) and Mary E. McLaughlin, R.N.

Rhode Island College of Education: Mr. Russell Meinhold; students, Robert Danilowicz, Richard Mainey and James Dolan.

Dr. Edgar J. Staff, Chief, Division of Laboratories, R. I. State Dept. of Health: Henry Archetto, Everett Weeden, George Weeden, Harold E. Pearson, William Hagan, Antonio Camilloni, Lawrence Paul, Barbara Bishop, Genevieve Shawcross, William B. Chase and Ralph G. Manning.

William E. Calderone, Director, Elmwood Clinical Laboratory; Miss Janice Fish, Mrs. Wesley K. Hall, Mrs. Walter Levy, Miss Eleanor Toegemann, Mrs. Elis A. Hanson, Dr. William P. Wilassich, Mr. J. Harold Krasnoff, Mr. Daniel V. Tramonti, Miss Barbara Fontaine, Mrs. Ralph S. Blydenburgh, Jr., Mrs. David Jones, Mr. Robert Crowell, Miss Phyllis Reynolds, Dorothy Saccoccia, Mrs. Everth Nelson and Esther Britzenhoff.

Dietitians: M. M. McLaughlin, V. A. Hospital, Davis Park; Mrs. Marjorie Ellis, Dietitian, Roger Williams Hospital; Miss Caroline Bolton, Roger Williams Hospital; Miss Helen MacLean, St. Joseph's Hospital; Miss Helen Tucker, Rhode Island Hospital; Mrs. Patricia Adams, Rhode Island Hospital; Miss Phyllis Bean, Rhode Island Hospital; Miss L. Taylor, Jane Brown Hospital; Miss A. Vanasse, Jane Brown Hospital; Mrs. Doris Lewis, Butler Hospital; Mrs. Ruth Dove, Wallum Lake; Miss Virginia Mears, State Institutions; Mrs. M. Brousseau, State Institutions; Dr. Constance Brine, School of Home Economics, U.R.I., and Miss Gertrude A. Cooke, V.A. Hospital.

Henry H. Babcock, M.D., Superintendent, Butler Hospital; Hugh L. C. Wilkerson, M.D., Medical Director, Diabetes Research, USPHS; Mr. William Connell, Chief, Temporary Disability Insurance Program, DES; Mr. Thomas A. Bride, Jr., Director Department of Employment Security; Mr. Max Brodsky, Eastern Scientific Company; Mr. Bo Bernstein; Mr. Louis C. Fitzgerald, and Mrs. Mary Savignac.

Chiropodists: Dr. A. Joseph O'Rourke, Dr. Frank N. Gurgess, Dr. Malcolm Ekstrand, Dr. Sheila A. Murphy and Dr. Barney R. Shaffer.

Mrs. R. Howland, Rhode Island League for Nursing; Miss Sally Knapp, Rhode Island League for Nursing; Miss Alice M. Knott, Social Service Department; Miss R. H. Howland, Nutrition and Diet Therapy, R. I. Hospital; Mrs. Williams, R.N., Smithfield Public Health League; Mrs. Sarah Nagle, R.N., Providence Health Department; Miss Helen Prince, R.N., Pawtucket V.N.A; Miss Nellie Dillon, R.N., Providence District Nursing Association and Mrs. Catherine O. Tracy, R.N., Bureau of Public Health Nursing, Dept. of Health.

LOUIS I. KRAMER, M.D., *Chairman*

HEALTH INSURANCE COMMITTEE

The committee has held no formal meetings this year as our activities are routine correspondence between the insurance carriers and the executive office. The committee stands ready, however, to handle any problems relating to insurance or to implement any direction from the House of Delegates.

The legal counsel for the society has received several copies of contracts offered by the Lincoln National Life and, after an exchange of letters regarding certain features thereof, the contracts have been approved.

Your chairman has officially notified the insurance carriers under the Rhode Island Plan of changes instituted by Physicians Service and a subcommittee has met with representatives of the Bureau of Accident and Health Underwriters.

As a part of this report the status of the Rhode Island Plan is herewith included for your information.

The committee is in receipt of the three-volume report of the commission for financing hospital care and notes that Rhode Island is one of the states wherein commercial coverage for voluntary hospital and medical expense insurance is at the lowest point.

Our Physicians Service evidently fills the need for Voluntary Medical and Surgical Care in Rhode Island.

CHARLES L. FARRELL, M.D., *Chairman*

INDUSTRIAL HEALTH COMMITTEE

The committee has met three times during the year. Discussion concerned phases of the new Workmen's Compensation Act; also regarding the possible renewable activity of the Rhode Island Industrial Physicians' Group.

The chairman has attended several group meetings of industrial safety engineers, had conferences with members of the Workmen's Compensation Board, continued review of the data on pesticides; attended the annual meeting of American Medical Association Council of Industrial Health (Washington, D.C.) and the annual meeting of the Industrial Medical Association at Buffalo, April 25-29.

Results of the state-wide poll of physicians interested in industrial medical work are not yet complete. At present, there have been 267 replies. Of these, 172 are associated in some way (or are interested) in industrial medicine; 95 replied in the negative. A further breakdown of types of medical work done by those replying affirmatively will be made and kept on file in the office of the executive secretary for reference.

STANLEY SPRAGUE, M.D., *Chairman*

MEDICAL DEFENSE AND GRIEVANCE COMMITTEE

The county-wide situation as to professional liability and insurance cause concern, and the committee repeats its advice of two years ago:

1) Carry sufficient professional liability insurance for peace of mind.
2) Avoid careless or critical remarks which might instigate as a suit against a fellow practitioner.
3) Think twice about suing a disgruntled patient for an overdue bill until the statute of limitation prevents a suit against you for malpractice, error, or mistake.

FRANCIS B. SARGENT, M.D., *Chairman*

MEDICAL-PHARMACEUTICAL COMMITTEE

There have been no outstanding changes made by the Medical Pharmaceutical Committee during this past year.

A meeting with the Rhode Island Pharmaceutical Association is anticipated some time this year to bring about better relations with the druggists in our community.

FRANK I. MATTEO, M.D., *Chairman*

continued on next page

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MENTAL HEALTH COMMITTEE

The Committee on Mental Health of the Rhode Island Medical Society met in the fall of 1954, in the Medical Library, Francis Street, in Providence, R. I. At that time, we were very much concerned with the relationship of clinical psychology to psychiatry. Our committee had been in contact with Mr. Kenneth Bosquet, who is the president of the Rhode Island Group of Clinical Psychologists. At this meeting in the fall, the chairman of the Committee on Mental Health, and Dr. Maurice Laufer, were delegated to meet with representatives of the group of clinical psychologists. In February, 1955, we met with Mr. Bosquet and Mr. Carl Pfaffer of the Psychology Department of Brown University. The main problem at that time was discussion of the protection of the public, the medical profession, and qualified clinical psychologists. The psychologists had the added problem of setting up standards for their own colleagues. The Rhode Island Group of Psychologists appear to be definitely in favor of certification rather than licensure. However, they have many problems of their own in setting up standards for certification, and it was a feeling of both sides in this matter, as long as no pressing problem of ethics existed in Rhode Island on this problem, that we both would avoid seeking any legal solutions and we would continue to meet informally to discuss our mutual problems and endeavor to work out a mutually agreeable solution. We plan to continue these meetings.

The committee met in March, 1955, with the Claims Committee of the Rhode Island Medical Society Physicians Service to discuss changes in the surgical insurance contract as they affected mental illness. The opinion of the committee, after recommendations from interested psychiatrists had been presented, was submitted to Physicians Service.

WALTER E. CAMPBELL, M.D., *Chairman*

NUTRITION COMMITTEE

Members of the Nutrition Committee have been well represented in the work of the Nutrition Council of Rhode Island and in the work pertaining to Diabetic Week.

However, the Committee has not been formally active this year, although the individuals of the committee have expressed their availability for any nutritional matters that might arise.

WILLIAM L. LEET, M.D., *Chairman*

PUBLIC LAWS COMMITTEE

The following report is presented relative to legislative proposals on medical and health matters presented to the Rhode Island General Assembly in 1955.

continued on page 410



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CANADA DRY GINGER ALE, Inc., New York, N. Y., *Sole Importer*

PUBLIC LAWS COMMITTEE

continued from page 408

Legislation Enacted

Undoubtedly the most important health legislation enacted by the Assembly at its recent session was that which provided for the creation of three major health districts in the state whereby the thirty-two towns therein would group for better health programs. Each town would pay 50% of its proportional share, based on population, of the cost of operating the district in which it is located. The legislation is permissive, and unless there is cooperation between the towns no progressive public health work will be accomplished through the new law.

The second major health act written into the law was an amended statute to regulate the possession, handling, control, dealing in, dispensing, etc. of barbiturates and other hypnotic and somnifacient drugs and derivatives thereof.

Several acts were introduced regarding nursing care. One that was passed provided $12,000 to be used as a scholarship fund for state beneficiaries to be trained as professional nurses. Another act extended the time for the commission studying the needs for enlarging the facilities for preparing practical nurses to report to the Assembly with recommendations. A proposal for a special survey commission to study the over-all nurse, and laboratory technician needs of the state for future planning was passed by the House, but left in Senate committee files.

The sum of $596,100 was appropriated for partial reimbursement to six voluntary general hospitals providing services for public ward patients, and $21,000 was given the Bradley Home to aid it to clear its 1954 deficit. The name of the state sanatorium at Wallum Lake was changed to the Dr. Ubaldo E. Zambarano Memorial Hospital.

In the regulation for benefits under the state temporary disability compensation and workmen's compensation programs several changes were effected. The temporary disability statute was amended to provide that it shall be applicable for employers of one or more instead of four or more, as formerly. The weekly benefit was raised from $25 to $30 starting January 1, 1956, and the taxes will be based on the first $3,600 of annual wages instead of the first $3,000. Municipalities were granted the option of placing their employees under the cash sickness program.

In workmen's compensation an unusual action was taken as regards payments for hospital accommodations of beneficiaries. The $12 per diem was removed and a provision written that the allowed amount "shall be the community prevailing rate for private patients occupying multiple bed accommo-

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PUBLIC LAWS COMMITTEE

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dations." This phraseology will certainly present some problems for the workmen's compensation commission in settling hospital accounts of injured workers.

Other acts made law included the following: a complete revision of the state's adoption rules; a provision that no body shall be cremated until a certificate is obtained from the medical examiner within the county where the body is to be cremated; a requirement that any city or town with ten or more mentally retarded children must provide facilities for their education, with the state appropriating $40,000 to share in the cost to the communities involved; authorization for the division of vocational rehabilitation to enter into an agreement with the secretary of health, education, and welfare to carry out the provisions of the Federal Social Security Act relative to the naming of determinations of disability under title II; and the creation of a seven-member commission to study the advisibility of providing free medical and hospital care for mothers of deceased veterans of any war.

Resolutions were enacted memorializing Congress to go forward with its proposed one and a quarter million dollar survey of the mental health problem in the United States, and citing the outstanding community service of the late Doctor Joseph C. O'Connell, past president of the Rhode Island Medical Society.

Proposals Not Enacted by Assembly

Among the health proposals, and medical licensure amendments not enacted by the Assembly were the following:

An act that would make the illegal practice of medicine a crime instead of misdemeanor as now listed; two acts affecting the practice of chiropractic, one which would make permissive public assistance payments for chiropractic services, and the other which would weaken the licensure requirements for such healers; a proposal that any person willfully refusing to yield a telephone line for an emergency call would be subject to fine or jail sentence; a proposal for a higher education compact in the New England States which started out to aid medical and dental education and legislative form included every possible kind of educational training; two proposals to provide Salk vaccine free to all school children; an act that would have created a special commission to study the shortage of registered nurses, medical and laboratory technicians; and permissive legislation for the town of East Providence to control air pollution.

JAMES H. FAGAN, M.D., *Chairman*

TUBERCULOSIS COMMITTEE

The Rhode Island Medical Society's Committee on Tuberculosis had one meeting at which there was a preliminary discussion of what might be done to speed up admissions of tuberculosis patients to the State Sanatorium. This matter, however, was taken over by official agencies, and we understand satisfactory arrangements were made for this.

JOHN C. HAM, M.D., *Chairman*



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1. J. Pharm. & Exp. Ther., 89:131
2. J. Urology, 73:487
3. J. Mo. Med. Assoc., 48:135
4. Med. Rec. & Annals, 43:1104

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Fifteen new titles have been added to the Davenport Collection and all but one may be borrowed:
Howard B. Adelmann—The Embryological Treatises of Hieronymus Fabricius of Aquapendente. The Formation of the Egg and of the Chick. (De Formatione Ovi et Pulli.) The Formed Fetus. (De Formato Foetu). A Facsimile Edition, with an Introduction, a Translation, and a Commentary. Cornell University Press, Ithaca, N.Y., 1942.
Erica Anderson—The World of Albert Schweitzer. A Book of Photographs. With Text and Captions by Eugene Exman. Harper & Brothers, N.Y., 1955.
William B. Bean — Omphalosophy and Worse Verse. Iowa City, Iowa. Gift of Dr. F. Ronchese.
Douglas G. Browne & E. V. Tullett—The Scalpel of Scotland Yard. The Life of Sir Bernard Spilsbury. E. P. Dutton and Company, Inc., N.Y., 1952.
Daniel Drake—Practical Essays on Medical Education and the Medical Profession in the United States, 1832. The Johns Hopkins Press, Balt., 1952.
Jacques Feschotte—Albert Schweitzer. An Introduction. With two Addresses by Albert Schweitzer. Beacon Press, Bost., 1955.
John F. Fulton—Michael Servetus, Humanist and Martyr. With a Bibliography of his Works and Census of Known Copies by Madeline E. Stanton. Herbert Reichner, N.Y., 1953.
Charles R. Joy, editor—Albert Schweitzer. An Anthology. Beacon Press, Bost., 1947.
Leslie T. Morton—Garrison and Morton's Medical Bibliography. An Annotated Check-list of Texts Illustrating the History of Medicine. 2nd ed. Argosy Bookstore, N.Y., 1954. Reference; not for circulation.
Oliver St. John Gogarty—It Isn't This Time of Year At All! An Unpremeditated Autobiography. Doubleday & Company, Inc., Garden City, N.Y., 1954.
William J. Maloney—George and John Armstrong of Castleton. Two Eighteenth-century Medical Pioneers. E. & S. Livingstone Ltd., Edin. & Lond., 1954.
Merrill Moore—Verse-Diary of a Psychiatrist. New Sonnets. Contemporary Poetry, Balt., 1954.
Leo Smollar & Neil Morgan—Know Your Doctor. Little, Brown and Company, Bost., 1953.
Dylan Thomas—The Doctor and the Devils. From the Story by Donald Taylor. New Directions, Norfolk, Conn., 1953.
Rhoda Truax—The Doctors Jacobi. Little, Brown and Company, Bost., 1952.
William Carlos Williams—Selected Essays. Random House, N.Y., 1954.

There has been one addition to the Gormly Collection, namely:
Law and Medicine, A Symposium. Journal of Public Law, vol. 3, no. 2, Fall 1954. Emory University Law School, Emory University, Georgia.

Books and journals have been purchased through the Donley Fund:
Daniel J. McCarthy & Kenneth M. Corrin—Medical Treatment of Mental Disease. The Toxic and Organic Basis of Psychiatry. J. B. Lippincott Company, Phil., 1955.
F.M.R. Walshe—Diseases of the Nervous System Described for Practitioner and Students. 8th ed. The Williams and Wilkins Company, Balt., 1955.
Journal of Nervous and Mental Disease, vols. 64, 67, 68 (bound). These volumes help to fill the gaps in our run of this important periodical.

Recent Day Fund purchases are:
Association of American Medical Colleges—Admission Requirements of American Medical Colleges. Chic., 1955.
Harry Beckman, editor—The Year Book of Drug Therapy (1954-1955 Year Book Series). Year Book Publishers, Inc. Chic., 1955.
Charles Herbert Best & Norman Burke Taylor—The Physiological Basis of Medical Practice. A Text in Applied Physiology. 6th ed. The Williams &Wilkins Company, Balt., 1955.
Walter Putnam Blount—Fractures in Children. The Williams & Wilkins Company, Balt., 1954.
Sir Macfarlane Burnet—Natural History of Infectious Disease. 2nd ed. Cambridge University Press, Cambridge, 1953.
James E. Bryan — Public Relations in Medical Practice. The Williams & Wilkins Company, Balt., 1954.
Stuart C. Cullen—Anesthesia in General Practice. 4th ed. Year Book Publishers, Inc., Chic., 1954.
Directory of Medical Specialists Holding Certification by American Boards. Volume VII. A. N. Marquis Company, Chic., 1955.
Allan J. Fleming, Constance A. D'Alonzo & J. A. Zapp—Modern Occupational Medicine. Lea & Febiger, Phil., 1954.

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Louis S. Goodman & Alfred Gilman—The Pharmacological Basis of Therapeutics. The Macmillan Company, N.Y., 1955.

Howard L. Holley & Warner W. Carlson—Potassium Metabolism in Health and Disease. Modern Medical Monographs. Grune & Stratton, N.Y., 1955.

Bernard Lown & Samuel A. Levine—Current Concepts in Digitalis Therapy. Little, Brown and Company, Bost., 1954.

S. Z. Levine & others, editors—Advances in Pediatrics. Volume VII. Year Book Publishers, Inc., Chic., 1955.

Ralph H. Major—A History of Medicine. Two volumes. Charles C Thomas, Springfield, Ill., 1954.

Charles W. Mayo—Surgery of the Small & Large Intestine. A Handbook of Operative Surgery. Year Book Publishers, Inc., Chic., 1955.

Thomas Hodge McGavack & others—The Thyroid. C. V. Mosby Company, St. L., 1951.

H. Houston Merritt—A Textbook of Neurology. Lea & Febiger, Phil., 1955.

Edwin J. Pulaski—Surgical Infections. Prophylaxis—Treatment—Antibiotic Therapy. Charles C Thomas, Springfield, Ill., 1954.

Herman Miles Somers & Anne Ramsay Somers—Workmen's Compensation. Prevention, Insurance, and Rehabilitation of Occupational Disability. John Wiley & Sons, Inc., N.Y., 1954.

Helen S. Willard & Clare S. Spackman, editors—Principles of Occupational Therapy. 2nd ed. J. B. Lippincott Company, Phil., 1954.

Irving S. Wright, Charles D. Marple & Dorothy Fahs Beck—Myocardial Infarction. Its Clinical Manifestations and Treatment with Anticoagulants. A Study of 1031 Cases. Grune & Stratton, N.Y., 1954.

Review volumes from the Rhode Island Medical Journal were:

Errett C. Albritton, editor—Standard Values in Nutrition and Metabolism. Being the second fascicle of a Handbook of Biological Data. W. B. Saunders Company, Phil., 1954.

Harry L. Alexander—Reactions with Drug Therapy. W. B. Saunders Company, Phil., 1955.

Fundamentals of Anesthesia. Prepared under the Editorial Direction of the Consultant Committee for Revision of Fundamentals of Anesthesia, a publication of the Council on Pharmacy and Chemistry of the American Medical Association. 3rd ed. W. B. Saunders Company, Phil., 1954.

Ronald Hare—Pomp and Pestilence. Infectious Disease, Its Origins and Conquest. The Philosophical Library, Inc., N.Y., 1955.

Thomas T. Mackie, George W. Hunter, III & C. Brooke Worth—A Manual of Tropical Medicine. 2nd ed. W. B. Saunders Company, Phil., 1954.

Alton Ochsner—Smoking and Cancer. A Doctor's Report. Julian Messner, Inc., N.Y., 1954.
C. Scarpa—Virus Dermotropi e Malattie da Virus in Dermatologia. Tipografia Saverio Pipola, Napoli, 1953.
Warren T. Vaughan—Practice of Allergy. Revised by J. Harvey Black. 3rd ed. C. V. Mosby Company, St. L., 1954.

Fellows of the Society have given the following items to the Library:

From *Dr. H. G. Partridge:* Edward Rigby—An Essay on the Uterine Haemorrhage, which precedes the Delivery of the Full-Grown Foetus: Illustrated with Cases. 3rd ed. Joseph Johnson, Lond., 1784, and
Johann Georg Roederer—Icones Uteri Humani Observationibus Illustratae. Gottingae, 1759.

From *Dr. F. Ronchese:* John Chiene—Looking Back, 1907-1860. Darien Press, Edin., 1908.
Italian-American Who's Who. A Biographical Dictionary of Italian American Leaders and Distinguished Italian residents of the United States. 3rd ed., Vigo Press, N.Y., 1938.
Dean Putnam Lockwood—Ugo Benzi. Medieval Philosopher and Physician, 1376-1439. University of Chicago Press., Chic., 1951.
S. I. Rainforth—The Stereoscopic Skin Clinic. Medical Art Publishing Co., N.Y., 1911.

From *Dr. S. Sprague:* Advisory Committee on Artificial Limbs—Artificial Limbs. A Review of Current Developments. Wash., 1954.
Eleanor C. Bailey & Elizabeth S. Frasier—A Time Study. Nursing Services in Small Manufacturing Plants. Public Health Service Publication No. 190, Wash., 1952.
Frances L. Hyslop & W. M. Gafafer—Bibliography of Occupational Health. 1909-1953. Public Health Service Publication No. 300. Wash., 1954.
Margaret C. Klem & Margaret F. McKiever—Management and Union Health and Medical Programs. Public Health Service Publication No. 329. Wash., 1953.
Margaret C. Klem & Margaret F. McKiever—Small Plant Health and Medical Programs. Public Health Service Publication No. 215. Wash., 1952.
Margaret C. Klem, Margaret F. McKiever & Walter J. Lear—Industrial Health and Medical Programs. Public Health Service Publication No. 15. Wash., 1950.
Victoria M. Trasko — Occupational Disease Reporting. A Review of Current Practices Together with a Collection of Incidence Statistics. Public Health Service Publication No. 288. Wash., 1953.
Victoria M. Trasko — Occupational Health and Safety Legislation. A Compilation of State Laws and Regulations. Public Health Service Publication No. 357. Wash., 1954.

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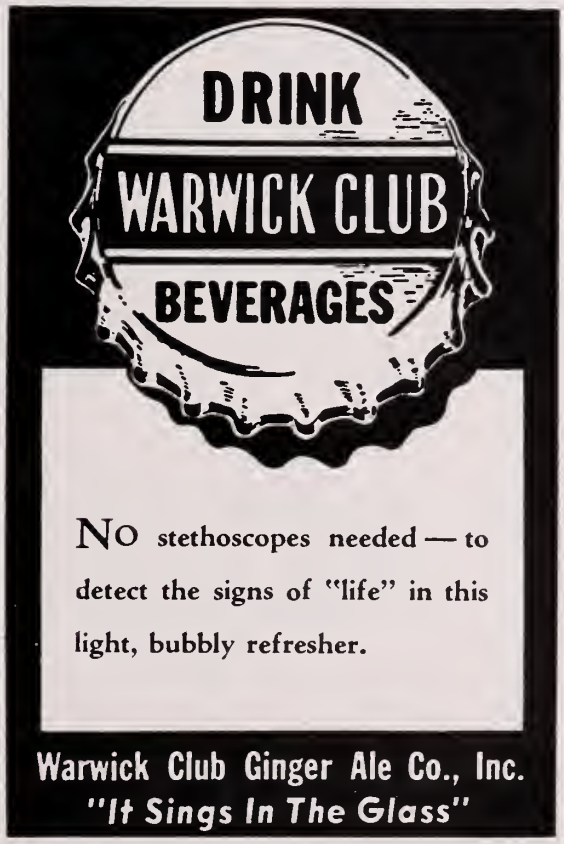
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Other gifts were:

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American Medical Association—Guide to Services. 3rd ed. Chic., 1955. Gift of the Association.

Army Medical Service Graduate School—Recent Advances in Medicine and Surgery (19-30 April 1954) Based on Professional Medical Experiences in Japan and Korea 1950-1953. 2 vols. Wash., 1955. Gift of the U.S. Government.

American Cancer Society. Annual Report 1954. Gift of the Society.

Donald J. Birmingham & Paul C. Campbell, Jr.—Occupational and Related Dermatoses. Public Health Service Publication No. 364. Wash., 1954. Gift of the U.S. Government.

Ciba Clinical Symposia vol. 6, 1954. Gift of Ciba Pharmaceutical Products, Inc.

Conference Papers Presented before the Tenth Clinical Conference of the Chicago Medical Society. Chic., 1954. Gift of the Society.

Collected Reprints, National Research Program of the American Cancer Society, 1953. 4 vols. N.Y., n.d. Gift of the Society.

Collected Reprints of the Grantees of the National Foundation for Infantile Paralysis, 1954. Vol. XV, pts. 1 & 2. N.Y., n.d. Gift of the Foundation.

Commission on Organization of the Executive Branch of the Government — Federal Medical Services. Wash., 1955. Gift of the A.M.A.

Committee on Medical Care for Industrial Workers—A Survey of Union Health Centers. Chic., 1954. Gift of the A.M.A.

Joseph L. DeCourcy & Cornelius B. DeCourcy—Pheochromocytoma and the General Practitioner. Cincinnati, 1952. Gift of Ciba Pharmaceutical Products, Inc.

Department of the Air Force—Flight Surgeon's Manual. Wash., 1954. Gift of the U.S. Government.

Department of the Air Force — Physiology of Flight. Wash., 1953. Gift of the U.S. Government.

Departments of Labor and Health, Education and Welfare Appropriations for 1956. Hearings before the Subcommittee of the Committee on Appropriations House of Representatives, Eighty-Fourth Congress. Wash., 1955.

Fifth Congreso Interamericano de Radiologia. Miembros des Congreso. 1955. Gift of Eastman Kodak Company.

M&R Pediatric Research Conferences, 9th and 12th, 1955. Gift of M&R Laboratories.

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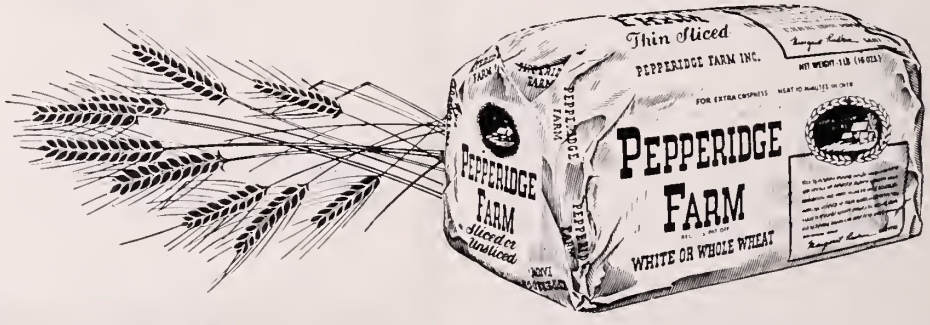
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F. Massey—Druze History. Detroit, 1952. Gift of Mr. M. S. Massoud, President of the Canadian-Arab Friendship League.

Edgar M. Medlar—The Behavior of Pulmonary Tuberculous Lesions. Reprinted from the Am. Rev. Tuberc. March 1955. Gift of Hermann M. Biggs Memorial Hospital.

Eugenio Morelli—The Treatment of Wounds of Lung and Pleura. Bost., 1920. Gift of St. Joseph's Hospital.

National Health Council—Health Careers Guidebook. N.Y., 1955. Gift of the National Health Council and the Equitable Life Assurance Society of the United States. Also, Partners for Health, N.Y., 1955.

Proceedings of the Second Annual Clinical Paraplegia Conference, August 25 through 27, 1953. Wash., 1954. Gift of the U.S. Government.

Proceedings of the 7th Annual Rural Health Conference, Raleigh, N.C., Sept. 29, 1954. Gift of the Medical Society of North Carolina.

Proceedings of the Sixth Annual Conference on the Nephrotic Syndrome. Edited by Jack Metcoff, M.D., N.Y., 1955. Gift of the National Nephrosis Foundation, Inc.

Providence Tuberculosis League. 1954 Annual Report. Prov., 1954. Gift of the League.

Report of the Bureau for the Blind for the Fiscal Year July 1, 1953 to June 30, 1954. Gift of the State of Rhode Island.

Rockefeller Foundation Annual Report, 1953. N.Y.,. Gift of the Foundation.

State of Minnesota—Report on a Study of Sickness and Disability Insurance Made by a Special Advisory Council in Cooperation with Department of Employment Security. St. Paul, 1954.

Studies from the Rockefeller Institute for Medical Research. Reprints, vol. 149, 1954. N.Y. Gift of the Institute.

Subcommittee on Noise in Industry of the Committee on Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology, January 1 to March 31, 1955. Quarterly Report No. 5.

Transactions of the American Association of Genito-Urinary Surgeons. Sixty-fifth Annual Meeting. Vol. XLVI, 1954. Balt. Gift of the Association.

Transactions of the American Proctologic Society, 1954. Fifty-third Annual Session. Gift of the Society.

Transactions of the South Central Section of the American Urological Association, 1954. Gift of the Association.

Transactions of the Western Section of the American Urological Association, vol. 21, 1954. Gift of the Association.

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U.S. Department of Agriculture, Bureau of Animal Industry—Index Catalogue of Medical and Veterinary Zoology. Sups. 3 & 4, Wash., 1955. Gift of the U.S. Government.
U.S. Department of Health, Education, and Welfare—Infant Care. Children's Bureau Publication No. 8, 1955. Gift of the U.S. Government.
Fredrick F. Yonkman & others—Reserpine in the Treatment of Neuropsychiatric, Neurological, and Related Clinical Problems. Ann. N.Y. Acad. Sc., vol. 61, Art. 1, pp. 1-280. N.Y., 1955. Two copies —Gift of the New York Academy of Sciences and of Mr Morton W. Saunders, Ciba Pharmaceutical Products, Inc.

BOOK REVIEW

"THE CARE OF YOUR SKIN" by Herbert Lawrence, M.D. Little, Brown & Company, Boston, 1955. $2.50

The author has presented a succinct text, on the problem of acne, comprehensible to the lay readers. His advice on treatment of acne is in accordance with accepted dermatological practice, and the reader would find it most informative.

New light is thrown upon many of the old taboos about the causes of the disease. In the last chapter, the author covers the emotional problems and their relation to acne, in a very interpretative manner.

I would recommend that physicians keep a copy in their waiting rooms for the edification of their patients.

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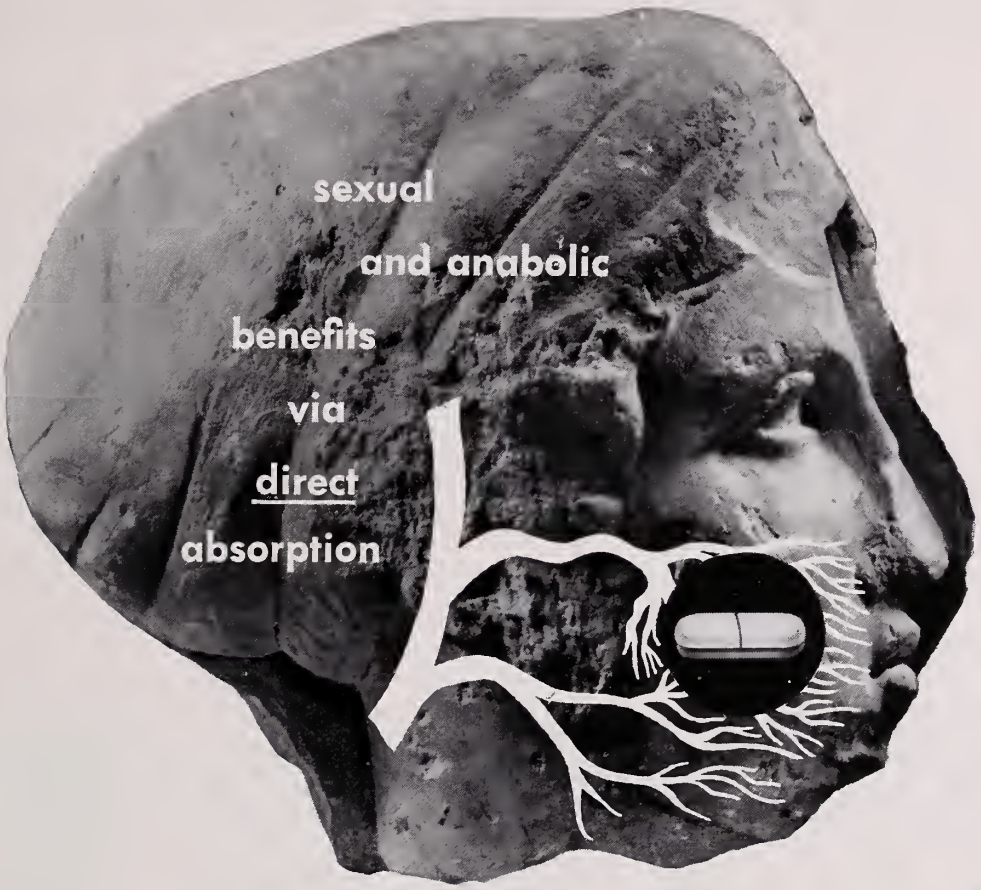
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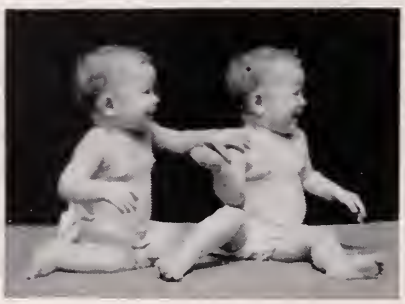


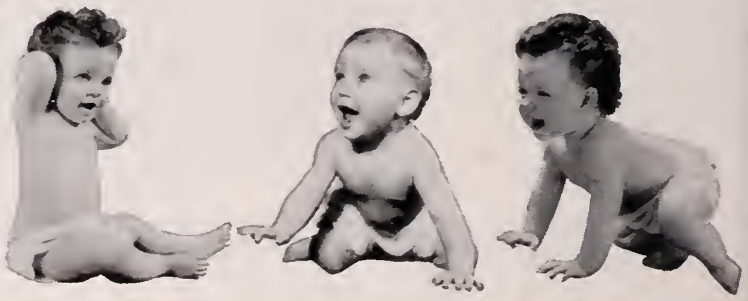
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(1) Jeans, P. C., in A. M. A. Handbook of Nutrition, ed. 2, Philadelphia, Blakiston, 1951, pp. 275-278.

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Education Discovers Mental Health . . .
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Observations on Some of the Newer Drugs . . .
See page 443



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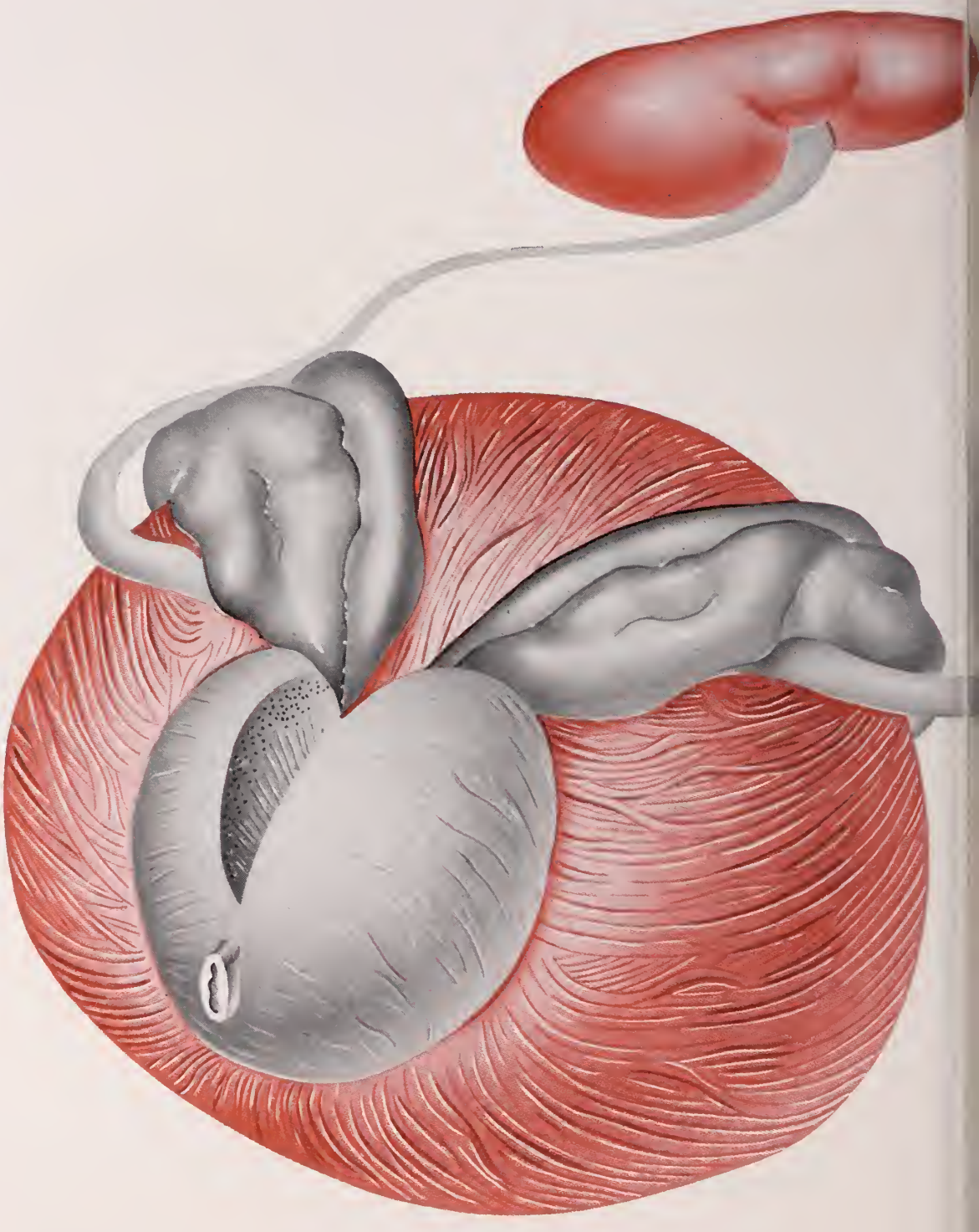
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References (1) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (2) Balch, H. H.: Mil. Surgeon 115:419, 1954. (3) Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W., & Elstun, W.: *J.A.M.A.* 157:305, 1955. (4) Kutscher, A. H.; Sequin, L.; Lewis, S.; Firo, J. D.; Zegarelli, E. V.; Rankow, R., & Segall, R.: *Antibiotics & Chemotherapy* 4:1023, 1954. (5) Clapper, W. E.; Wood, D. C., & Burdette, R. I.: *Antibiotics & Chemotherapy* 4:978, 1954. (6) Sanford, J. P.; Favour, C. B.; Harrison, J. H., & Mao, F. H.: *New England J. Med.* 251:810, 1954. (7) Sanford, J. P.; Favour, C. B., & Mao, F. H.: *J. Lab. & Clin. Med.* 45:540, 1955. (8) Felshin, G.: *J. Am. M. Women's A.* 10:51, 1955.

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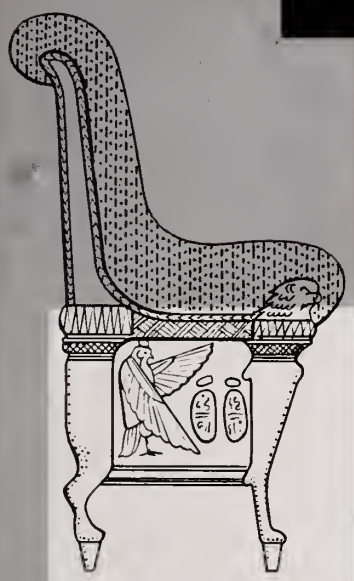
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1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. Med. 53:2233, 1953. **2.** Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951. **3.** Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery 18:512, 1949. **4.** Turell, R.: New York St. J. Med. 50:2282, 1950. **5.** Marks, M. M.: Missouri Med. 52:187, 1955.



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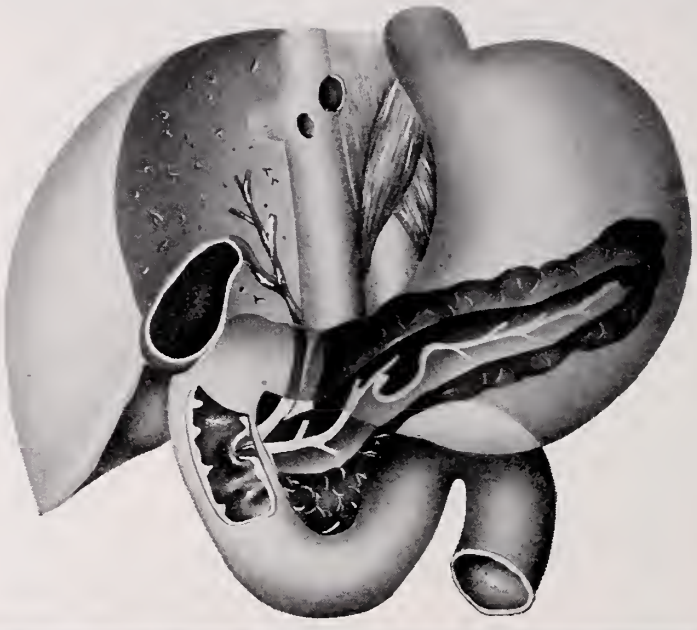
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*Combes, F. C. & Canizares, O.: New York St. J. Med. 52:706, 1952; Marsh, W. C.: U. S. Armed Forces M. J. 1:1045, 1950.

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1. Rechtman, A. M., and Yarrow, M. W.: Osteoporosis, Am. Pract. & Digest Treat. 5:691 (Sept.) 1954.

2. Cannon, P. R.; Frazier, L. E., and Hughes, R. H.: Factors Influencing Amino Acid Utilization in Tissue Protein Synthesis, in Symposium on Protein Metabolism, New York, The National Vitamin Foundation, Inc., 1954, pp. 55-90.

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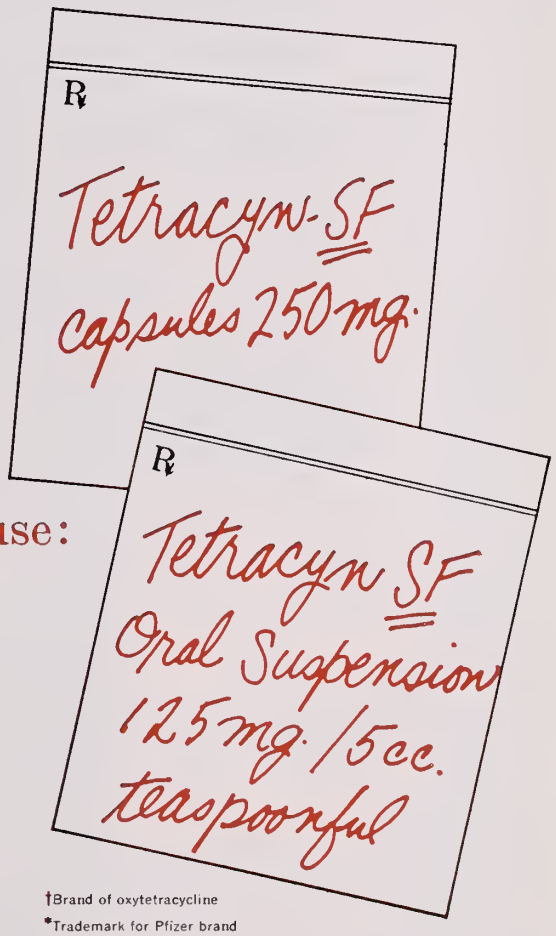
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1. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, Prepared in Collaboration with the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Washington, D. C., 1952. 2. Martí-Ibáñez, F.: Antibiotic Med. *1*:247 (May) 1955. 3. Dumas, K. J.; Carlozzi, M., and Wright, W. A.: Antibiotic Med. *1*:296 (May) 1955. 4. Milberg, M. B., and Michael, M., Jr.: Ann. New York Acad. Sc., In press. 5. Prigot, A.: Ibid.

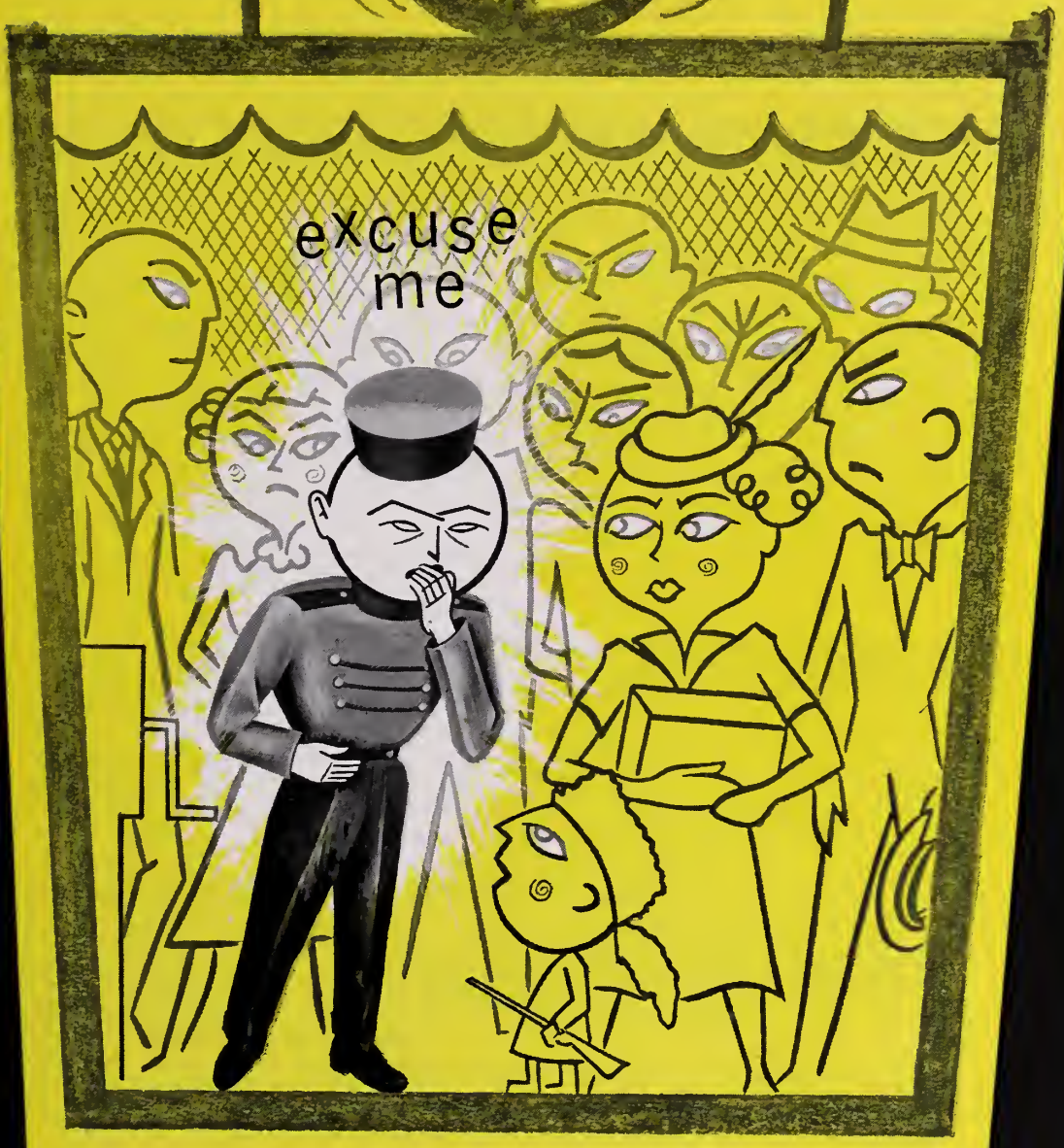
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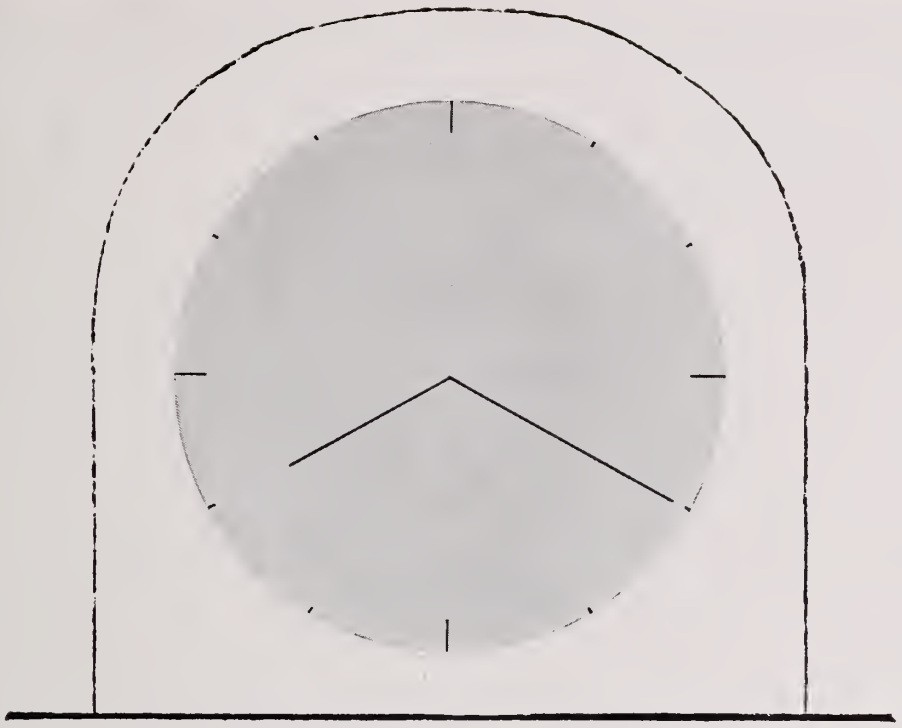
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1. Science News Letter, March 1954
2. Greenblatt, R. B.: Obstet. & Gyn. 2:530, 1953

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Levin, S. J. Ped. Cl. of N. A. 1:975,1954.

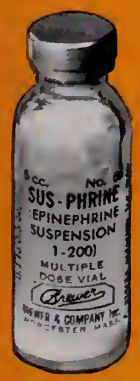
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Naterman, H. L. The Journ. of Allergy. 24:60,1953.

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Unger, A. H. and Unger, L. Annals of Allergy. 10:128,1952.

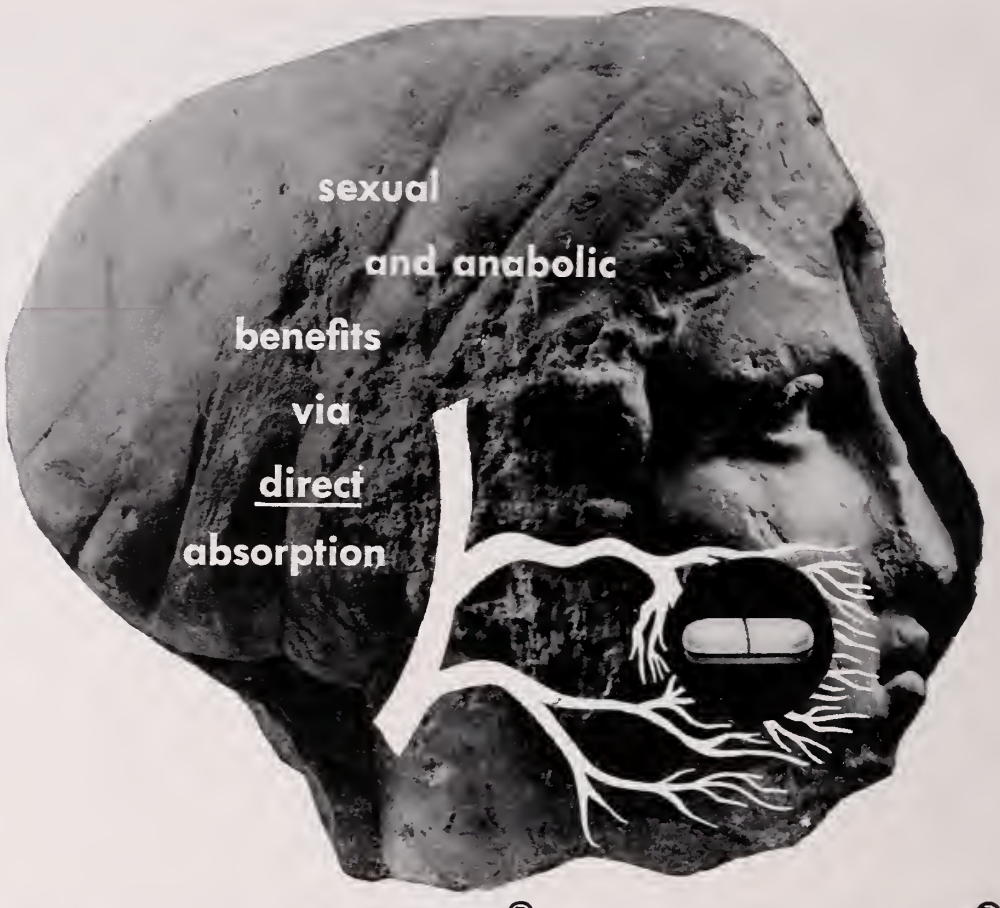
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXVIII AUGUST, 1955 NO. 8

THE ARTHUR HILER RUGGLES ORATION

EDUCATION DISCOVERS MENTAL HEALTH*

DANA L. FARNSWORTH, M.D.

The Author. *Dana L. Farnsworth, M.D., of Boston, Massachusetts, Henry K. Oliver Professor of Hygiene, and Director of University Health Services, Harvard University.*

To give an oration in honor of Doctor Ruggles is itself a pleasure for any psychiatrist. To give an oration in honor of a man who as much as any man has founded the relatively new field of college psychiatry is indeed a privilege, especially to one who has spent his entire professional life looking after young men and women of college age.

In honoring Doctor Ruggles in this regard, one must not forget Doctors Smiley Blanton, Karl Menninger, H. M. Kerns, Austen Fox Riggs, and others who were pioneers in this field. Especially is honor due to the dean of college psychiatrists from the point of view of length of service and breadth and depth of contribution, Doctor Clements C. Fry of Yale University. Doctor Fry was a younger colleague of Doctor Ruggles at Yale, and so in honoring him we are once again seeing one of the many beneficent influences of Doctor Ruggles.

As you know better than I do, Doctor Ruggles has contributed to this community, the state, and the nation in many different ways. Likewise he served in the United States Army during World War I. In addition to being the superintendent of Butler Hospital for so many years, he was very active in the American Psychiatric Association, being both its secretary and president. He has acted as consultant for many different organizations.

At this time we are not going to consider these major aspects of his professional life but will focus our attention on one portion of psychiatry, concerning which he has had a major interest all his professional life. That field is the application of psychiatry to the problems of teaching and learning in colleges and universities.

A psychiatrist who is interested in this field is concerned not only with the therapy of disturbed students and faculty members, but also finds it to his advantage to be interested in a wide variety of emotional, social, and educational problems. This, Doctor Ruggles displayed. As Doctor Gregory Zilboorg described Doctor Ruggles more than a decade ago, he has consistently been interested in problems of mental hygiene and psychiatric public health, in research, and "of studying patients in order to cure them, but also to rob them of the secrets of their illnesses in order to find new and ever more real and scientific cures."

In the fall of 1923, Doctor Ruggles responded to an invitation to inaugurate and develop the work in mental hygiene at Dartmouth College. When that program was well established, he returned to his work at Butler, only to repeat the process in the fall of 1925 at Yale University. He combined his work at Yale with that of directing the activities of the Connecticut State Mental Hygiene Association, thus maintaining a breadth of view regarding students and community problems which is highly desirable. For the first six months at Yale Doctor Ruggles worked alone—seeing student patients, lecturing at the Medical School, doing community service, and generally acquainting both town and gown with the nature of the work being done. During the second semester of that year, he secured an assistant, and then at the end of the year returned to Butler. The wisdom of the planning and groundwork which he laid down at that time has been adequately demonstrated by the fact that Yale University now has, and has had for many years a psychiatric service in its Department of Student Health which is surpassed by none in the country. His interest in this field has continued from that time to the present.

It will now be our purpose to review this great field of mental health in our colleges and universities. I shall hope to show you what it was that induced Doctor Ruggles to participate actively in this field in the early days, and then to examine the nature of this work, what it has become, and what some of its potentialities may be.

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Mental Hygiene of College Students

When we look back to the earliest beginnings of interest in the emotional lives of students, we find only slight hints recorded here and there in the writings of educators and others. Mark Hopkins[1] was always interested in the best ways of encouraging the learning process, saying among other things that a good mind should not be forced too early. Furthermore, he understood the motivations of students, and knew, as most of his faculty did not, that strong leadership does not depend upon abrupt authoritarian attitudes and procedures. He once said, "That college is in the best state in which the least government is necessary." Later on in the same address he asserted "that there should be such an intercourse and state of feeling that the officers and students can go on harmoniously together and feel that they have a common object." The famous comments of President Stearns of Amherst in 1856 also indicated a high degree of awareness that there were strong forces within the students' own personalities that needed attention by the policy makers of educational institutions. He thought that "the breaking down of the health of students, especially in the spring of the year, which is exceedingly common, involving the necessity of leaving college in many instances, and crippling the energies and destroying the prospects of not a few who remain, is in my opinion wholly unnecessary if proper measures could be taken to prevent it." We are still trying to formulate those "proper measures."

In the meetings of the American College Health Association in the middle 1920's a gradually increasing amount of interest, as reflected in the published proceedings, began to be shown in the mental hygiene of college students. One speaker thought there should be someone in the college who would speak to those students who were obviously not doing well for emotional reasons and tell them to get enough sleep and eat a proper diet in order that they might work effectively. Another physician, who happened to be a psychiatrist, said he didn't think this was enough, that someone needed to deal with the disturbed students and find out their backgrounds, motives, and conflicts. This caused considerable concern, bringing up the question as to whether it was necessary for a health service of a college or university to have a psychiatrist on its staff.

The combination of the scarcity of psychiatrists interested in the mental health of college students and the reticence, resistance, lack of awareness, and the lack of financial resources in colleges that need aid in developing the emotional maturation of their students has resulted in slow progress in this field. At present not more than thirty psychiatrists devote their full time to college mental health, and the number who give a significant amount of time to this field is probably not over two hundred. When these statistics are considered alongside the fact that there are about 2,500,000 college students at this time, and the prospects of twice as many in fifteen years, the magnitude of our problem is revealed.

Awareness of the need for including consideration of emotional development along with intellectual growth is rapidly increasing. In an informal survey of opinion of more than one hundred presidents of leading colleges and universities in the United States prior to the Fourth National Conference on Health in Colleges in New York City in 1954, the chief problem that bothered these presidents in the field of health was the emotional difficulties of their students. Deans' organizations have included consideration of mental health in their programs to an increasing degree since World War II. Counseling programs of various kinds have been developing, in some places stimulated by health services, in others by faculty committees, and in others by departments of psychology, or by religious advisers.

The clinical problems encountered by a college psychiatrist or psychologist include early schizophrenic reactions, a few hypomanic forms of behavior, and numerous depressions, as well as all manner of neurotic reactions. Aside from the disorders of old age, the types of psychiatric illnesses are more or less similar to those of the community generally. There is, however, a striking qualitative difference in dealing with college students. The clinician then sees people of superior intelligence for the most part, who are "fresh from their symptoms," whose adaptive mechanisms have not yet become atrophied from lack of use, and who are usually desirous of getting on with their work as soon as possible. Occupational therapy, the development of leisure time activity, combating boredom, and all such collateral activities are well taken care of in the college setting. Treatment results usually obtainable in months or years may frequently be obtained in days or weeks when dealing with young and rapidly developing students. Since so many of the treatment problems are relatively acute, the psychiatrist is pleasantly surprised to observe evidences of psychopathology which in other settings might be gravely disturbing, but which, in this special, and usually favorable, atmosphere are likely to represent transient phases of reaction to stress. The inborn strong tendencies toward normality and a kind of emotional homeostasis are very strong at this age period.

The natural tendency of a psychiatrist who is called upon to practice his profession among college students is to think of them, especially the disturbed ones, in terms of psychopathological syndromes. If

this thinking is reflected too strongly in conversations with referring faculty members, deans, or student leaders, an undue amount of anxiety and resistance may be built up, causing a lack of appreciation of what the psychiatrist has to contribute to the work of an educational institution. Most of the difficulties to which students are reacting are combinations of current unhappy situations, usually not of major importance, and earlier experiences and resultant attitudes, which are frequently of enormous significance. When the difficulties of students are discussed with other members of the college (observing with great care the usual confidential nature of personal interviews) in terms of these general background experiences, the material is not particularly threatening and such exchanges of information form ideal vehicles for teaching and learning in the vast field of emotional reactions.

Major Emotional Hazards

In the earlier lives of those students who are most likely to need help during their college careers, and at least ten per cent of all students do need such help each year, are a number of general situations which recur with sufficient frequency to lead me to believe that they should be known to all persons interested in mental health. If known and appreciated, they would go far to aid in formulating those "proper measures" desired by President Stearns to improve student efficiency.

These major constellations of emotional hazards might be summarized as follows:

1) Parental discord or friction.
2) Rigidity in thought, behavior, and emotional expression in those with whom the growing person has had close and intimate contact.
3) Inconsistent or absent discipline.
4) Relative lack of masculine attributes in the father and feminine traits in the mother.
5) Teaching by direct and indirect methods of distorted or squeamish attitudes toward body functions at an early age.
6) Living in a poor neighborhood environment.
7) Inadequate mental ability in comparison to other members of the family, even though quite good in comparison to the general population.

In the educational scheme of things the problem is not only that of devising methods by which individual students who are handicapped by emotional blocks can be helped toward a higher level of accomplishment and satisfaction, but more important, the development of a greater degree of awareness on the part of all members of the community of the emotional needs of all human beings. Such awareness should in the long run serve to improve the level of intellectual accomplishment, since it is almost axiomatic that a student who feels right about himself and other people can learn more quickly than one who is checkmated by hostility, anxiety, frustration, conflict, and isolation.

In a college setting the psychiatrist in a literal sense functions as a teacher in those situations in which the individual finds himself blocked or prevented from applying his energies effectively to his studies or other activities in which he desires to engage. Psychotherapy has many of the characteristics of education; in fact, it is a teaching and learning process of a very special kind, involving conscious and unconscious material. It can equally well be said that good education partakes of many of the characteristics of psychotherapy. New horizons are opened up, and old obstacles removed. A sense of freedom is attained, usually after a period of confusion. In the usual institution of learning the great bulk of the teaching and learning goes on in a subject matter orientation, and is carried on or supervised by a teacher who thinks primarily in terms of gaining familiarity and mastery of certain facts and skills. The teaching and learning that goes on in the psychotherapeutic frame of reference is usually oriented to the person and the problem, and is supervised by a psychiatrist or psychologist who thinks primarily in terms of the personality characteristics of the individual and the way he handles internal and external stresses and strains. It should be the function of the teacher and the psychotherapist to devise adequate and frequent means of communication, whereby each can learn more about the other's point of view. The more the psychiatrist knows of the teacher's goals and quandaries and the student's "normal" difficulties, the better he should be able to care for the emotionally disturbed or the ineffectual students. Similarly the teacher will be immeasurably aided in the improvement of his teaching if he is aware of those strong forces, conscious and unconscious, that facilitate or impede learning. In a sense the psychiatrist is constantly engaged in trying to increase understanding of people so as to make his own specialized approach less and less necessary. In this give and take between the teacher of subject matter and the teacher of personality attributes, neither is in a position of superiority. Each must be as eager to learn as he is ready to teach.

As the psychiatrist working in a college or university begins to look beyond the immediate task of caring for individual students who may be referred to him or who come to him of their own volition, his interests may be attracted to a wide variety of situations and practices that have considerable relation to mental health. Among these are the attitudes of students and faculty members toward one another. Are the upperclassmen-underclassmen reticent about talking to faculty

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members lest they be considered by their fellows as engaging in apple-polishing? Do the faculty members feel faintly intolerant of the confused and immature students? How many teachers on the faculty have a thorough-going knowledge of personality development and the characteristics of the late adolescent or young adult who comes to his classes for information, guidance, and stimulation?

Of great interest to the psychiatrist on the college campus is the matter of discipline. If the attitude of the administrative authorities is one of keeping the students in line, keeping them under control, and punishing them for their misdemeanors when they occur, it should not be unexpected when the situation degenerates into a kind of game of "cops and robbers." If, on the other hand, the attitude of administrative leaders is that students should learn to manage themselves, efforts are made in hundreds of different ways to develop a sense of responsibility and freedom, student government is encouraged and strengthened, then true discipline and built-in responsibility is at least a possibility.

The psychiatrist is also interested in overemphasis on grades, in the prevalence of cheating, in the presence of competition for its own sake or competitiveness, as I prefer to call it, and in the attitudes of students toward other schools and colleges. He is also interested in the anti-intellectual trends of students as they are expressed in the activities of some fraternities, in hazing, in the improper use of medical excuse systems, in reacting to political pressures, and in the way social activities are carried on. Some students may need to be rescued from isolation by getting them into more social activities. Others may have used the same activities as an escape from some of their own inner insecurities and conflicts. The presence of low morale in any division of the college or in its housing units is a subject of great interest.

Whether or not the school or any part of it practices unfair discrimination or shows undue prejudice is also of concern. The way students, faculty, and visitors are treated by employees makes a great deal of difference in what the general public thinks of the educational institution. The tradition of friendliness around a college is not something that grows up accidentally. It has to be encouraged and cultivated, and this is done most effectively by the people at the top working through all the individuals with whom they come in contact.

In recent years there have been increasing efforts on the part of athletic organizations and college officials to clean up the deplorable state of athletics in some colleges, particularly in football. The college which allows athletes to be subsidized financially because of their athletic prowess is teaching dishonesty just as effectively and possibly more so than if it had classes in how to get your man elected without going to jail. Alumni influence, usually good but occasionally having undesirable results, is a profitable subject for consideration.

Research Problems Numerous

Research problems in the field of college mental health are numerous indeed. The great area of student motivation needs careful consideration. There are various bits of evidence to suggest that there is a direct relationship between the quality of parental relationships and effectiveness in academic accomplishment. If so, ways and means should be found to detect those incoming students who have a better than average chance of getting into difficulty and helping them before they become failures. The causes of failure need careful study in many colleges. In one college in which 88 first-year men left during the year for personal reasons, it was noted by the dean that at least 39 of them had severe emotional problems connected with members of their own families. How attitudes can be changed for the better needs careful consideration. Likewise the various causes of frustration, hostility, aggressive behavior, and other such states of mind need careful elaboration. How the psychiatrist can help the various types of counselors that are engaged in helping students is in need of urgent study. In fact, the whole process of counseling is of primary interest to the psychiatrist and the opportunities for him to exercise influence through other people has no more promising outlet than through this one. No one has yet come up with any acceptable definition of the difference between counseling and psychotherapy, though it is obvious to all that there is a difference. The lack of clarity of functions in the two fields may lead to undesirable rivalries or unfair criticisms by one group or another.

A very great need is that of devising, through research techniques, methods whereby knowledge derived from emotionally disturbed students may be organized and transmitted in usable form to teachers and students in such a way as to facilitate the learning process. In other words, what are the emotional blocks to learning and how may they be removed?

The next great area for college mental health is that of trying to improve the educational process itself by widening its scope to include formal attention to the emotions by all students.

My thesis is that education should include more than knowledge and intellectual power. Education and educators should acknowledge that skill in handling emotional conflicts and tensions and the training of character are just as important as traditional subject matter. Furthermore, the adoption of this concept should serve in the long run to raise standards of accomplishment in the purely intellectual pursuits, not lower or dilute them.

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OBSERVATIONS ON SOME OF THE NEWER DRUGS*

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In the past decade we have experienced a most interesting and exciting change in our attitudes and beliefs concerning the use of drugs in the treatment of patients. At the turn of the century there was very little interest in drug therapy outside of a very small group who were confined mainly to laboratory studies of the action of a very few really worthwhile therapeutic substances. The medical leaders of that period, such as Sir William Osler, who, in spite of some beliefs to the contrary, was deeply interested in therapy, but who was realistic enough to realize that most of the substances in use in the treatment of disease were, for the most part, useless and perhaps in some cases definitely harmful. He, as did others at the time, developed a very healthy skepticism in regard to these preparations, and as a consequence, hundreds of useless substances were discarded.

This was, indeed, a very fortunate state of affairs and certainly cleared the way to a more realistic approach to the problem of drug therapy. Unfortunately, the result of the widespread abandonment of many formerly thought to be useful therapeutic substances led students of these leaders to develop a very skeptical attitude toward all drug therapy, and for a period of time in the early part of the twentieth century there was a definite feeling of therapeutic nihilism in many clinics. This attitude led some to a state of mind whereby the main and perhaps sole effort was placed in the problem of diagnosis and left them with little or no enthusiasm to carry on definitive therapy once the diagnosis had been made.

This part of the care of the patient was frequently delegated to much less experienced individuals, who, being surrounded by the air of apathy as regards therapeutic matters, were not too enthusiastic to carry on any system of treatment. At times this lack of interest closely bordered upon neglect. Although, in view of the lack of many really worthwhile agents, probably no great disservice was done the patient other than perhaps a loss of some confidence in the physician and medicine in general. Not infrequently patients handled incompetently would seek relief elsewhere, particularly at the hands of various quack practitioners, which, as we all know, flourished mightily during this period.

With the advent of the sulfa drugs in 1937, there became available a most valuable therapeutic tool. These substances were at first largely ignored by the medical world, and at this time the thinking was such that it was indeed difficult to find much in the more widely read medical literature concerning them. Once, however, the real efficacy of these substances penetrated the barrier of therapeutic skepticism, there again rose the hope that chemists and pharmacologists, working in conjunction with clinicians, were capable of producing specific agents for the treatment of disease. Everywhere there was a revival of interest in therapy which has continued to increase in a rapid fashion so that now there is a constant stream of new substances appearing. Some of these have highly specific properties and are of great value in the treatment of various disease or abnormal physiological states. Indeed, the therapeutic enthusiasm in the last five years has been so great as to outstrip the ability of those treating the patients to keep properly informed concerning them. Entire new fields of therapeutic endeavors have appeared, and the number of really worthwhile agents now available with specific action is indeed impressive.

In view of these rapid advances in therapy, and with the appearance of numerous agents, some good, some not so good, and some useless, the author thought it might be of interest to review a few of the fields of drug therapy and endeavor to point out some of the more interesting developments which seem to him to be of sufficient merit to warrant consideration.

Anti-Infectious Agents

Penicillin still remains our most useful agent in this field. There is no doubt that the advent of this drug was one of the great developments of all time, and it is by far the most satisfactory therapeutic agent known. It is the most widely used of the

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antibiotic substances, and, in spite of its massive use in millions of people, it has produced a very little in the way of side effects in the vast majority of individuals, and it is exceedingly effective against all organisms susceptible to its action. For the most part very little resistance on the part of organisms has developed to it except in the case of the staphylococcus.[1]

We must, however, give note to the increasing incidents of reactions to this excellent preparation. In 1951, six fatalities were reported as a result of penicillin injections. By 1953-54, at least fifty fatalities had been reported.[2] Kern has stated that the commonest cause of anaphylactic shock is penicillin.[3]

It is not surprising that this agent is now one of the most common sensitizers. For example, better than 350 tons of penicillin is consumed a year in this country, and when one considers that one milligram is equivalent to 1600 some units, it is readily apparent that the amount of the drug used is in fantastic portions. Therefore, it is not at all surprising that cases of allergy are appearing and constantly increasing.

It is known, of course, that the penicillin molecule is capable of combining with serum albumin and that the resulting combination is an antigenic substance. [2] Penicillin itself, however, is not antigenic even in patients who are hypersensitive to the penicillin protein mixture.

Of the penicillin preparations in use, procaine penicillin G seems to be the chief offender in allergic reactions. It is exceedingly difficult to accumulate reliable figures on the degree of hypersensitive reactions, but what is available indicates that in approximately 10% of patients who have had penicillin applied topically there develops dermatitis or other reactions to the agent. In patients receiving penicillin by mouth or by injection, approximately 5% develop urticaria which may appear immediately or from seven to fourteen days after the drug has been discontinued. Unfortunately, once the urticaria develops, it may persist for months. In a very small per cent, certainly less than 1%, systemic reactions of various kinds are known to occur with the drug. Of these, the serum sickness-like reaction occurs in about 0.12%. This reaction, which consists of fever, arthralgia, and a variety of dermatological lesions may occur immediately, or develop from two to five weeks after the penicillin has been given. Finally, a very small group of patients develop a severe anaphylactic shock-like reaction to the oral or intramuscular injection of penicillin. In a survey made within the last two years, eighty-eight cases of severe anaphylactic reactions were found, of which eighteen amongst this series were fatal. At the present time over two hundred anaphylactic reactions and better than fifty fatalities have been reported, and the number grows with each survey made.[2]

Therefore, we must not consider this drug as being totally without harm, and, consequently, must govern ourselves in its proper use. Undoubtedly, a large percentage of penicillin is used without sound bacteriological survey, and no one knows, but certainly a very high percentage of the use is directed against situations where the drug probably has little or no effect, such as virus infections or infections by organism which are insensitive to the agent. Many of the reactions occur in patients who have an allergic family history or personal history and in those who have received the drug previously. Certainly, in such individuals physicians must use precautions if some of these undesirable effects are to be avoided.

Where there is reasonable doubt, a simple skin test is sometimes effective in picking up reactors. This is done by a solution containing 10,000 units of crystalline penicillin per cc. applied to a scratch on the skin. Usually, within fifteen to twenty minutes a wheal or flare will develop if definite allergy is present. This test will quite frequently pick up the patient who would develop urticarial reactions and those most likely to get an anaphylactic effect. It will, however, not be very effective against the serum sickness-like reactions which take a longer time to develop. Although in some of these patients a skin reaction will develop in twenty-four to forty-eight hours.[4]

Once sensitivity to penicillin has developed, it is very difficult to know how long it will persist. Many of the milder reactions disappear within a period of one to two years. However, severe allergic reactions to the drug probably persist for life.

In summary, it would be wise to follow these precautions: Use penicillin only when it is definitely needed and indicated; do not apply it by topical applications to the skin; use the simple crystalline preparations where possible; and in any patient with an allergic diathesis a skin test should be done before administering the drug.

Tetracyclines

This important triad of antibiotics consisting of chlortetracycline (aureomycin), oxytetracycline (terramycin), and tetracycline occupies a very important position in the antibiotic family. They are broad spectrum agents which are absorbed by mouth and are widely distributed in the body after absorption. In spite of the great amount of attention being given to these agents and many claims for first one and then the other, it is apparent from their chemical structure that they are very closely related substances, and that although there may be slight variations in certain characteristics, on the whole, they behave with a great deal of uniformity. All of them can cause irritation of the gastro-

intestinal tract resulting in nausea and vomiting, diarrhoea, and rectal irritation, and it is thought by some if there is any degree of liver impairment that they can produce a jaundice because of their property of being concentrated in the bile in competition to the normal elimination of bile pigment.[5] This, however, does not mean that they are toxic to the liver *per se,* but it is reasonable to assume that there is some interference with aerobic phosphorylation and that the drug should be promptly discontinued. As yet, there has been observed very little allergy to these substances; certainly much less than had been observed with penicillin. This, however, may well be just a matter of time and amount consumed rather than something inherent in the molecule.

One of the most serious complications following the use of these agents is superinfection of the gastrointestinal tract with resistant staphylococcus. This is a very serious situation and can develop quite rapidly without much warning. Enough of these superinfections have developed to make those of us who are using these preparations to be on the constant alert through proper bacteriological studies to avoid, head off, or treat this most serious complication. Another annoying, but much less serious, complication is the development of candida Albicans infections. These normally harmless yeasts under the favorable conditions created by chlortetracycline especially may propagate and become of sufficient importance to cause serious pathological lesions. Generally, however, the importance of the yeast infections with antibiotics has been over stressed. There is, however, fortunately, a new agent which is highly effective against these infections, which I shall discuss in a moment. Certainly, the tetracyclines are a most useful class of antibiotics, and they are most valuable in the treatment of infection involving wide bacterial spectrum such as peritonitis, meningitis, and the rickettsial group of organs.

Fungicidin (Nystatin)

This new antibiotic developed by Hazen and Brown in 1951 from streptomyces noursei[6] exerts a powerful anti-fungicidal effect against such agents as candida Albicans and inhibits or kills all species of fungi and yeast with the exception of the actinomyces. Apparently, it is most effective in the growing stage of the yeast and not very effective against the spores. It exerts no effect against bacteria. Forunately, the material is rather poorly absorbed from the gastrointestinal tract and most appears in the stool when given by mouth. It has low toxicity, but nausea and vomiting have been reported following its use. Patients tolerate large doses, however, even as much as 6,000,000 units daily for months. The usual dose is 500,000 units, one tablet, three times a day, but this can be doubled whenever necessary. Usually, in two or three days with fungicidin the diarrhoea, ano-rectal syndrome, oral lesions, and ulcerative lesions along the bowel pretty much disappear.[7] This was so even though tetracycline therapy is continued. There are other very interesting properties concerning this new preparation such as activity against Histoplams Capsulatum in mice, but as yet there is not sufficient data to really be certain what it means.[8]

Nitrofurantoin (Furadantin)

Another development in the antibiotic field in recent months has been the appearance of a new nitrofuran derivative. This substance has very interesting properties which may make it a useful agent in the treatment of infections of the genito-urinary tract. From what little work has been done to the present time it appears that this substance effects organisms through a different system than is attacked by the sulfonamides and other antibiotic agents, because it has been shown that it is effective against organisms resistant to these substances. Another favorable feature concerning this substance is that resistance is apparently developed rather slowly, and in some organisms it is almost impossible for resistance to develop. After oral administration there develops very low blood levels because the drug is quickly concentrated in the kidney and excreted in levels as high as 40 mg. per 100 cc. in the urine. Only traces are found in the feces, and there is little or no effect upon intestinal bacterial concentration. It is apparently rapidly excreted and must be given at six-hour intervals or less, in order to keep an adequate concentration in the urine. Since it is effective against E. *coli,* the staphylococcus albus and aureus, streptococcus fecales, and the paracolon bacteria, it is proving to be a useful agent in genito-urinary tract infections.[9] A dose of 5 to 8 mg. per kg. in twenty-four hours divided into four portions and given after meals and upon retiring is commonly employed. As yet the only toxic signs that have developed have been nausea and vomiting, which occurs in about 12% of the patients. Although our experience with it as yet has been limited, the results so far have been favorable.

Tranquilizing Agents

Within the past three years there have appeared two very interesting substances, namely chlorpromazine and reserpine. These agents behave in a unique way in that they bring about a quieting down of much of the mental activity of patients without true depression of the higher cortex. It appears as if the effect is exerted in the thalamic region. These substances have occasioned a great deal of interest since they seem to have such widespread uses in therapy. Chlorpromazine, a synthetic material of the antihistaminic series, which in itself, however, has very weak anti-histaminic effect, was prepared

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in France by the Rhone-Poulenc research group and was first used in France as an agent to relieve agitated, highly excited patients with severe manic tendencies. It was also used by the French in hibernation therapy as a useful adjunct in surgery.[10] In this country it has found use as a powerful antiemetic agent and as an agent to quiet highly excited patients from many difficulties such as manic psychoses, the undesirable agitation created by chronic alcoholism, drug addiction, and other tension producing conditions.[11,12,13,14] In general, chlorpromazine is tolerated exceedingly well by the vast majority of patients. Occasionally a hypotensive episode is produced when the drug is given, but usually this is a passing significance, and if the patient is lowered to a horizontal position with the head down, the effect rapidly passes off.

There is a sedating effect produced in that a fairly good percentage of patients when first started upon the drug develop drowsiness, and this in some patients may be quite significant and force discontinuance of the agent. In general, however, as the drug is continued, the drowsiness seems to disappear and the patient is not aware that he is on any therapy.

Early there was noticed a rather severe reaction to this drug in the form of jaundice. This was found to be an obstructive-like jaundice. There also appeared an eosinophilia in many of the cases, highly suggesting that this may well have an allergic basis in the very limited number of patients in which it does occur. Most of the cases of jaundice were mild in character and cleared promptly when the drug was withdrawn. However, a few patients have continued to be jaundiced for long periods of time; one up to several months. Biopsies of the liver have shown very little in the way of parenchymal damage but considerable blockage of bile passages with some infiltration around the bile ducts.[15] Usually, the jaundice appeared after the drug had been given for two or more weeks in a dose of 100 mg. a day. Many people have remarked about the similarity between this type of jaundice and that which occurs with methyltestosterone. Some observers feel that the obstructive jaundice in these cases is brought about by the action of chlorpromazine on the biliary structures leading to lessened peristalsis and paralysis of normal biliary activity with perhaps spasm or failure of the sphincter of Oddi to relax. Recently one case of agranulocytosis has been reported with the drug and there has come to my attention two other incidents of this very serious complication.[16] It is, however, not surprising that these reactions develop when a drug of this nature is so widely used in the general population. It remains to be seen, however, whether the toxic effects will become more prominent as the drug is given on repeated occasions to individuals. As yet it is too early to tell just what degree of toxicity will result from its widespread use. There is no doubt, however, that the drug is highly effective in many situations. We have observed its ability to control nausea and vomiting from a large variety of situations which otherwise were unamenable to any form of therapy that had been applied. This action is exerted against the chemoreceptor trigger area of the vomiting center. The effect it exerts on the agitated, unhappy, tremulous, excited, uncomfortable, chronic alcoholic is very pleasing. The patient loses the nausea, vomiting, anorexic reactions that are usually present and promptly quiets down and feels much more relaxed and able to continue about his affairs. When we first used the drug we employed it in combination with disulfram (antabuse), but later work by ourselves and others amply demonstrated that the real activity lies in the chlorpromazine itself and not the combination. The drug has also been used in pruritis of various types. We have observed its effect in patients with neurodermatitis-like syndromes where it usually exerts a definitely ameliorating effect. It removes to a great extent much of the nervous tension that underlies these conditions while it also apparently exerts a central effect against the itching tendency. It, however, will not completely stop malignant neuro-dermatitis in our experience.

Reserpine: The other tranquilizing agent which is also a very unique substance, Rauwolfia Serpentina was in the crude form used for centuries in India. A crystalline derivative, reserpine, recently has been prepared, and its chemistry has been ascertained. Reserpine slows heart rate, lowers mildly hypertensive blood pressures, and definitely brings about a quieting state from mental tension.[17] This drug has to a large extent replaced phenobarbital in the more labile hypertensives; certainly in those with a rapid pulse rate and a fluctuating type of hypertension. It is a very useful agent in the treatment of agitated mental states.[18] It usually increases appetite and causes some irritation of the gastrointestinal tract. This latter condition may be serious enough at times to produce definite gastrointestinal difficulty, leading to cramps, diarrhoea, and in an occasional patient forcing the discontinuance of the drug. It also causes stuffiness of the nose, and this congestion at times in hypertensive patients can be of sufficient degree as to lead to severe epistaxis. An occasional patient may get sinus blockage from this and have a severe sinus infection as a consequence of therapy. The drug, however, for the most part is very well tolerated, and large doses can be given without any apparent serious consequences. As yet, very little in the way of drug allergy has appeared, and certainly it does not exert sudden dramatic toxic effects as is ob-

served with so many of the potent preparations in use.

Interestingly enough, both chlorpromazine and reserpine can be given in a wide variety of doses without producing much in the way of toxic effects. For example, patients have attempted suicide with chlorpromazine, taking as much as 500 to 1,000 mg. apparently without producing any serious reactions. Massive doses of resperine (as many as 1040 (0.25 mg.) tablets have been taken by a child weighing only 32 pounds without any serious consequences. Interestingly enough, both chlorpromazine and reserpine bring about in certain patients a condition which is indistinguishable from that of Parkinsonism. This has created a great deal of interest in the mechanism of action of these drugs. Apparently, there is somewhat more rigidity than tremor produced and this leads one to think that the globus pallidus is more severely influenced by the drugs than the cortex or other portions of the brain.

Anti-Hypertensive Drugs

Unfortunately, time does not permit me to give a detailed discussion of the new hypertensive agents which are now being used in the treatment of hypertension. It is sufficient perhaps to say that as yet we have not developed a satisfactory agent in the treatment of this disease. Certainly, the hexamethoniums and other ganglionic blocking substances, including pentapyrolidium (ansolysin), are not without undesirable side effects, and for the most part are not practical in long-term treatment of this condition. The oral dosage regulation with all ganglionic blocking agents is highly unsatisfactory because of the inherent nature of their action. Most patients rebel at the idea of continued injections and the carrying around of blood pressure machines. Furthermore, the side effects, irregular action, and toxic properties have diminished much of the early enthusiasm.

Hydrazaline (apresoline) should for the most part be abandoned in therapy. It has been definitely shown to exert highly toxic effects in a fairly high percentage of patients, and for the most part is not really beneficial in the long-term treatment of hypertension because of the fact that it causes undesirable increased cardiac work.

In our hypertensive clinic we have been making use of a combination of drugs which so far in our hands has shown to be about 60% effective in the treatment of rather severe hypertension. This combination consists of an adrenergic blocking agent, phenoxybenzamine (dibenzyline) 5.0 mg., protoveratrine 0.2 mg., and Rauwolfia serpentina 25 mg.* With this combination we have secured good results in patients with moderately severe hypertension with a minimum of toxic side effects. It is apparent from animal experiments and from our work in patients that these agents certainly exert an additive if not a synegistic effect in the treatment of hypertension. It, however, still leaves much to be desired, and as yet we must continue the search for a more satisfactory agent for the treatment of hypertension.

I would like to discuss briefly a drug which has caused considerable worry amongst those of us who are interested in drug therapy. This is the preparation phenylbutazone (butazolidin). This agent, a close relative of amidopyrine, has been widely accepted for the treatment of arthritis and gout. There is no doubt that it does have some ameliorating effect in both of these situations, particularly in the treatment of gout. However, owing to the chemical nature of the substance, a high percentage of it is combined with serum protein, and as a consequence, allergenic substances are created. In a series of 3,900 patients there were 1,515 reactions. A recent survey of the reactions to this drug indicates that about 32% of the patients receiving it get some form of a reaction. In approximately 12% of these, the reactions are severe enough to force discontinuance of the drug. Up to the present time there have been twenty-four deaths reported from its use. In spite of efforts to prevent or detect early toxicity to the drug, there have occurred serious toxic reactions and death. Unfortunately, even after the drug has been discontinued, it is capable of producing severe destructive lesions in the bone marrow and elsewhere in the body. Reducing the total daily dose has, for example, cut reactions from as much as 75% in patients receiving 1200 mg. or more daily to only 34% in patients receiving 400 mg. a day. However, in view of the fact that it is so difficult to know who is and who is not going to get a reaction, and in view of the fact that there is no method of sufficient accuracy to give an adequate warning as to when a reaction is going to occur, it seems to those of us who have watched the use of this drug that exceeding care should be used in its administration, certainly very small dosages should be employed and other therapy substituted wherever possible. On the whole it seems undesirable to use drugs with inherent serious toxic propensities in symptomatic treatment.

Another agent which I would like to briefly discuss with you is one which has been in use for many years in various fields of medicine, and this is ammonium chloride. At the present time ammonium chloride is used widely as a diuretic agent in congestive heart failure. Unfortunately, we are continually seeing cases who have developed toxicity to this excellent agent. Apparently, this is brought

*Now available as the Smith, Kline & French Laboratories preparation (Mio-Pressin No. 2).

continued on page 466

AMA DELEGATES' REPORT
104th ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION
at Atlantic City, New Jersey, June 6-10, 1955

CHARLES J. ASHWORTH, M.D., *Delegate*, AND ARTHUR E. HARDY, M.D., *Alternate Delegate*

ONE OF THE highlights of the 104th annual meeting of the American Medical Association at Atlantic City occurred on Sunday, June 5, at the Conference of Presidents and Other Officers of State Medical Associations. In addition to its local interest the address of president-elect of the Rhode Island Medical Society as incoming president of the Conference attracted national publicity and deluged Doctor Farrell with requests for reprints as well as requests for personal appearances at state and county medical meetings in several states.

Speaking to the subject *A Reappraisal of Medico-Economic Problems*, our president-elect of the Rhode Island Medical Society emphasized the increasing urgency and importance of the influence of these factors on medicine and every individual who practices the art, covering such items as voluntary health insurance, social security, reinsurance, financing hospital care, hospital-physician relationship and osteopathy, among others. Doctor Farrell urged all state societies to initiate means for a more intensive analysis and study of these various problems as their impact upon medicine increases constantly.

The selection of a candidate for president-elect of the A.M.A. is always an item on the agenda of the House of exceeding importance. The choice this year of Doctor Dwight H. Murray of Napa, California, met with unanimous approval. He was unopposed. Chairmanship of the board of trustees for the past four years of his ten-year membership has qualified Doctor Murray with an exceptional background of administrative experience to succeed next year to the presidency of the American Medical Association. He is a general practitioner enjoying a busy professional life.

Doctor Donald G. Balfour, noted author and surgeon at the Mayo Clinic in Rochester, Minnesota, was voted the 1955 Distinguished Service Award of the American Medical Association by the House of Delegates. A member of the Mayo Clinic since 1907, Doctor Balfour has also been associate director and director of the Mayo Foundation for Medical Education and Research. Doctor William Balfour, his son, accepted the award for his father at the inaugural program of the meeting.

Medical ethics, medical practices, intern training, hospital accreditation, polio vaccine and osteopathy were among the major topics of discussion before the House of Delegates. At the opening session of the House retiring A.M.A. president Doctor Walter B. Martin, of Norfolk, Virginia, again pointed out that the basic philosophy of medicine has not changed and that "our obligation is to bring the best that medicine can offer to the individual patient." Doctor Elmer Hess of Erie, Pennsylvania, now president of the A.M.A. stressed the obligation of the nation's physicians to "overcome the ravages of mental illness" as well as to become leaders in an "intensive campaign to eliminate the needless blood shed" of traffic accidents. In his inaugural address, nationally broadcast, Doctor Hess said that "unless we are willing to give of ourselves and our faith, our science will avail us little." Doctor Norman Vincent Peale, widely-known clergyman, shared the speaking spotlight with Doctor Hess on "Medicine's Proclamation of Faith" inaugural program.

The osteopathic issue, the most controversial at this session of the House, was referred to the Committee on Medical Education and Hospitals. A large number of interested persons attended this reference committee's deliberations. Two reports were submitted to the House after considering the recommendations of the Committee for the Study of Relations between Osteopathy and Medicine. The minority report, ultimately adopted by the House of Delegates, said in part:

"One member of the Reference Committee was completely satisfied that an appreciable portion of current education in colleges of osteopathy definitely does constitute the teaching of 'cultist' healing, and is an index that the 'osteopathic concept' still persists in current osteopathic practice. Since he cannot with good conscience approve the recommendation that doctors of medicine teach in osteopathic colleges where 'cultism' is part of the curriculum, he respectfully makes the following recommendations to the House of Delegates:

"1) That the report of the Committee for the Study of Relations between Osteopathy and Medicine be received and filed; and that the committee be thanked for its diligent work, and be discontinued.

"2) That if and when the House of Delegates of the American Osteopathic Association, their

official policy-making body, may voluntarily abandon the commonly so-called 'osteopathic concept,' with proper deletion of said 'osteopathic concept' from catalogs of their colleges; and may approach the trustees of the American Medical Association with a request for further discussion of the relations of osteopathy and medicine, then the said trustees shall appoint another special committee for such discussion."

The majority report of the reference committee, which was rejected by the House, made the following recommendations:

"Your Reference Committee after a study of the report of the Committee for the Study of Relations between Osteopathy and Medicine and the study of other evidence submitted is not completely satisfied that the current education in colleges of osteopathy is free of the teaching of 'cultist' healing.

"In view of the desire to elevate the standards of teaching in colleges of osteopathy, your reference committee recommends approval of the recommendation of the committee that doctors of medicine may accept invitations to assist in osteopathic undergraduate and post-graduate medical educational programs in those states in which such participation is not contrary to the announced policy of the respective county and state medical associations. Such teaching services would be ethical.

"Your reference committee approves the recommendation of the committee that the House of Delegates request state medical associations to assume the responsibility of determining the relationship of doctors of medicine to doctors of osteopathy within their respective states or request their component county societies to do so.

"Your reference committee recommends that a committee be appointed at the discretion of the board of trustees to confer with representatives of the American Osteopathic Association concerning common or inter-professional problems on the national level."

Medical Practices Committee Report

The Reference Committee on Insurance and Medical Service, which considered two board of trustees reports on the Report of the Committee on Medical Practices, recommended endorsement of the board's principal conclusions and recommendations. The House of Delegates, however, adopted a substitute motion postponing action until next December. The motion also called for distribution of the entire report of the Committee on Medical Practices to all delegates, so that they can study it carefully before the 1955 Clinical Meeting in Boston.

Internship Approval Programs

The House adopted the following statement presented by the Reference Committee on Medical Education and Hospitals:

"Your committee has reviewed the report of the Council on Medical Education and Hospitals which includes a summary of the reports previously made to the House of Delegates by the Ad Hoc Committee on Internships and are in agreement with the council that these conclusions and recommendations are eminently sound and that they should be incorporated into the principles and policies employed by the council in the conduct of its internship approval programs including subsequent revisions of the Essentials of an Approved Internship.

"Your Committee wishes specifically to reaffirm the following recommendations of the Ad Hoc Committee on Internships:

"1) That a continuing study be made as to what should be the content of an internship; what constitutes sound clinical experience during the internship year.

"2) That the 'one-fourth rule' be adopted: Any internship program that in two successive years does not obtain one-fourth of its stated complement be disapproved for intern training. It was pointed out to your committee in the hearings that statistical data compiled for a period of two years indicated that enforcement of this rule would have displaced only a few interns."

Hospital Accreditation

The same reference committee considered six resolutions on hospital accreditation and presented the following statement which was adopted by the House:

"Your reference committee has reviewed all these resolutions which in principle are similar and apparently reflect a widespread dissatisfaction with the present functioning of the Joint Commission on the Accreditation of Hospitals, possibly from bilateral misunderstandings. Therefore, your reference committee recommends that the speaker of the House of Delegates be requested to appoint a special committee to review the functions of the joint commission on the Accreditation of Hospitals to consist of seven members, none of whom shall be members of the Council on Medical Education and Hospitals or the Joint Commission on the Accreditation of Hospitals. This special committee should be instructed to make an independent study or survey and report its findings and recommendations to the House of Delegates at the next annual meeting. All physicians and hospitals are urged to pass on to this special committee any observations or suggestions concerning the functioning of the Joint Commission on the Accreditation of Hospitals."

continued on next page

INTERIM MEETING

of the

RHODE ISLAND MEDICAL SOCIETY

Wednesday, October 26

at the

R. I. Medical Society Library

FRANK B. CUTTS, M.D., President, *Presiding*

3:00 p.m. . . .

SYMPOSIUM ON DISEASES OF THE COLON

Speakers

FRANZ J. INGELFINGER, M.D., *of Boston, Massachusetts*

CLAUDE E. WELCH, M.D., *of Boston, Massachusetts*

JOHN H. GARLOCK, M.D., *of New York, New York*

RICHARD SCHATZKI, M.D., *of Boston, Massachusetts*

6:00-7:00 p.m. . . .

Reception at the Narragansett Hotel

Members of the Society, the Auxiliary, and their Guests

7:00 p.m. . . .

Dinner, Narragansett Hotel
Speaker: DR. HUGH SHIELDS

Polio Vaccine

The House passed three resolutions suggested by the Reference Committee on Hygiene, Public Health and Industrial Health in connection with discussion of the Salk polio vaccine and the introduction of new methods in the treatment or prevention of disease.

The first resolution reaffirmed "confidence in the established methods of announcing new and possibly beneficial methods in the treatment and prevention of disease" and also reaffirmed "the need for the presentation of reports on medical research before established scientific groups, allowing free discussion and criticism, and the publication of such reports, including methods employed and data acquired on which the results and conclusions are based, in recognized scientific publications."

The second resolution included the following policy statements:

"Resolved, That the American Medical Association go on record as disapproving the purchase and distribution of the Salk polio vaccine by any agency of the federal government except for those unable to procure it for themselves and that such necessary federal funds therefor be allocated to the various proper state agencies for such purpose; and be it further

"Resolved, That the American Medical Association urge the Congress of the United States to allow the Salk polio vaccine to be produced, distributed and administered in accordance with past procedures on any new drug or vaccine."

The third resolution commended Dr. Salk as follows:

"Whereas, The physicians of this country recognize the great scientific achievement in isolating and perfecting a vaccine for the prevention of poliomyelitis by Dr. Jonas Salk; and

"Whereas, This vaccine is now being used to prevent poliomyelitis among many of our children; therefore be it

"Resolved, That the House of Delegates express its profound gratitude to Dr. Salk and its admiration for his monumental contribution to medical science."

concluded on page 454

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The RHODE ISLAND MEDICAL JOURNAL

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BUTLER HOSPITAL

RHODE ISLAND PHYSICIANS will note with genuine regret the closing of Butler Hospital on September 1, 1955. Rhode Island's oldest hospital has provided psychiatric care for patients continuously since December 1, 1847. Having been organized three years prior to that time, it has now completed a hundred and eleven years of stimulating and rewarding service, both to the medical profession and to the citizens of our State.

Since the Board of Trustees of the hospital announced in April of this year that financial problems would make it necessary to cease operations shortly unless outside assistance could be obtained, tremendous public interest has been shown. This has been expressed through all channels of communication, and the various opinions, sentiments and criticisms are evidences of a heart-warming concern for the fate and future of this fine institution.

Widespread interest and sentiment is well justified by Butler Hospital's long and illustrious past. It came into existence in 1844 as the result of two large financial gifts and a public campaign for funds to match one of these. The campaign was successful and was presumably the first community fund-raising campaign conducted in Rhode Island. A large sum, raised primarily from small givers, assured widespread interest and investment in the new project. The leadership of the hospital throughout its hundred and eleven years of service has been outstanding. Its eight superintendents have been conspicuous in the medical world for their stature in the field of psychiatry. The hospital has served as a leading training center for psychiatrists, particularly during recent years. For over fifty years its training school for psychiatric nurses has been outstanding. Many Rhode Island physicians other than those practicing psychiatry have a warm personal attachment for Butler Hospital, either by virtue of having received part of their training within its walls or having served as consultants to its staff. Since its founding, its Board of Trustees has consisted of civic leaders, many of whom have served for impressively long periods of years with consistent devotion to the interests of the hospital. A tradition of weekly visits by committees of trustees has assured them an intimate and up-to-date awareness of the many details of the hospital's operation and its problems. Gifts, donations, bequests and other tangible and intangible contributions have been made to Butler Hospital by many persons. Some of these have been in gratitude for personal

continued on next page

medical benefits resulting from treatment to friends and relatives, and others have served as expressions of civic interest and responsibility. The hospital's famous psychiatric library, its gracious buildings and its beautiful grounds have made it for generations very much a part of the local scene. No wonder that interest has run high and strong feelings have been expressed as to the future of an institution in which so many of us feel we share a responsibility.

Various reports made public in recent weeks by the Board of Trustees, by the hospital superintendent and by professional and lay committees which have been consulted document many important current medical and economic problems. From the physician's point of view, a variety of developments in psychiatric treatment have tended to decrease the demand for expensive, long-term private care such as Butler Hospital provided. Among these have been the prompt benefits to many patients of electroconvulsive therapy, eliminating the necessity for prolonged hospitalization. Moreover, increasing numbers of psychiatrists practicing in the community are willing to treat psychiatric patients outside the hospital, particularly when their management is facilitated by some of the new drugs which have become available in the very recent past. More and more general hospitals are providing some facilities for psychiatric care. The very great expense of prolonged treatment in a private mental hospital whose overhead costs are high due to the small number of patients involved has forced many families to seek public rather than private hospitalization for long-term treatment for such relatives as need it.

The decision to close Butler Hospital has been made primarily for economic and financial reasons. An increasing annual operating deficit has reached such proportions as to make it apparent that the hospital's general funds would before long be completely exhausted if some radical alteration in plans for the future were not made. Substantial financial gifts from donors to an amount adequate to compensate for operating losses can no longer be expected, although hospital annals of years ago indicate that at one time the situation was far different. The decision to close the hospital has been made by the Board of Trustees, whose legal responsibility it is to manage the hospital's affairs. The decision was made after months of serious study, with the assistance of experienced and qualified consultants. The possibility of continuing the operation of Butler Hospital under the auspices of the State of Rhode Island was carefully evaluated by a committee appointed for the purpose by Governor Roberts early this past spring and was found to be impractical.

The Committee on Mental Health of the Rhode Island Medical Society has officially expressed the concern of the Society at the closure of Butler Hospital. Its report indicates that not only immediate medical services to the community, but also opportunities for the training of psychiatrists and for future research, as well as a break in a century-old tradition of outstanding psychiatric institutional care, are matters of concern, and possibly some responsibility, for the entire medical profession. The members of the Committee on Mental Health have offered their assistance and that of the entire medical profession in exploring possibilities for the future use of Butler Hospital's assets in the interests of psychiatry and mental health.

We have not been altogether in favor of the completely open hospital where any man who has passed his medical examinations could take in patients and do whatever he wished for them. We do not think that the best medicine will be practiced unless there is some kind of oversight over the men doing it. We certainly think that if Butler opened its doors it should only do so to well-qualified psychiatrists, but we know that there are a number of these in our communities and we feel that they should take a part in the institutional care of their patients.

When we come to the question of the government of the hospital we realize that the Governing Board must be largely made up of men with a different, if not broader, outlook on life than what medical men have. There are many economic and social reasons why hospitals need this, but there is always the paramount necessity of the primary object of a hospital to be considered and we feel that only the medical profession is fully qualified for this.

The Providence Lying-In Hospital has been very successful with a physician and women on its Board of Trustees. We feel that under modern conditions this is a very wise procedure. Also the Board of Trustees should be broadened in other ways beyond what it has been in the past. Some of our strongest groups have not been associated with this as, for instance, the Catholic Charities and the strong Jewish element who have recently made a success of their new hospital, and also some of the leaders of our big racial groups which, of course, were very small at the time Butler Hospital was founded.

We are not altogether convinced by some of the arguments that have been recently presented. Much has been made of the fact that the buildings and equipment of Butler are outmoded. Certainly in this age of glorified sheds for residences and skyscrapers for all businesses Butler is out of date. We feel that much of this may be a question of fashion and not progress. It is many years since in the home of Harvard and the Massachusetts General Hospital the Peter Bent Brigham Hospital was built. Nowhere could one find persons better quali-

fied to pass on the style of a new hospital than there were in Boston. They decided on a pavilion type of hospital. The Swaben Hospital in Munich, Germany, now taken over by the American Armed Forces, is a pavilion hospital and a fine one. We think it very possible that within a few years ideas regarding the shape of hospitals will change again, and that it will be considered advisable to move patients and equipment for long distances along a level floor rather than to fight gravity and move them aloft in some of the restricted elevators.

Another thing. Butler Hospital is in a most beautifully isolated park. We do not believe that the psychiatric wing attached to a modern hospital resembling a factory in its appearance and surroundings will be so good for this purpose.

Modern hospitals are so much a part of the "hard material world of today where so much is worth preserving is being jettisoned in the name of progress." A psychiatric hospital should consider this even more than other hospitals. We trust that Butler Hospital will be re-organized, but not abolished.

OUR LIBRARY

One of the busy workers who knows well what is going on at the Rhode Island Medical Library, was visiting a big metropolis the other day. He had occasion to go to the medical library of one of the county societies in close connection with, if not a part of, the aforesaid metropolis. The members of that society are numbered in thousands where our state society is numbered in hundreds. One might naturally expect that the medical library of that organization (which by the way they seem to be rather proud of) would make our little collection of books and other things related to medicine appear rather meager. On the contrary, he was rather shocked by what he saw there. The answer is that his standards have been built up to a very high point by his associations in our little state.

Our Society was founded in the early part of the last century. For many years after that books were held in higher esteem than we are inclined to think that they are at the present day. The climax was reached when Dr. Hersey started his remarkable collection of medical writings. If a scholar had knowledge and good judgment he could pick up valuable items for little money in those days and this Dr. Hersey proceeded to do. If one will visit the Miller Room at our Library he will see there a wonderful collection of valuable ancient tomes.

Our community has always been an intellectual center and many of our members made for their own libraries a good collection of contemporary works. Many of those collections naturally came to us. The most remarkable of them all, unique as far as we know, is the Davenport Collection of the extra-professional writings of physicians. Dr. Davenport, as well as being a brilliant surgeon, was also a man of rare taste with an unusual interest in literature. At his death we got his forty-year-old collection and since that time it has been added to judiciously.

Originally our books were kept at the Providence Public Library and in the latter part of their stay Miss Grace E. Dickerman was in charge of them. When in 1912, our centenary, our library building was built, the books came here accompanied by Miss Dickerman who has been here ever since. Mrs. David C. DeJong, a graduate of Pembroke College, has now been librarian for a number of years. We are happy to think that no medical library could be better run than ours is under her direction. We are sure that she will tell you that the oversight that she has received from some of our members has been a wonderful help to her. We do not know too much detail about the relationship of the older members to our Library—Mrs. DeJong tells us that Dr. Timothy Newell was librarian for many, many years and a most enthusiastic worker—but beginning with Dr. Hersey such men as Dr. Herbert Partridge, who loves books and associates with them constantly, Dr. John Donley, a classicist and a bibliophile, and our present chairman of the Library Committee, Dr. Irving A. Beck, are establishing a fine tradition of scholarship here.

One other thing. Although our Library is primarily for the medical profession we are always glad to extend its services to rich man, poor man . . . lawyer or even Indian chief. All we ask is that they have genuine worthwhile interest in our contents. They may be sure of willing, clever help from our staff in working out their problems.

Our Library is indeed a public institution in its desire to help everyone as far as we have facilities. We know of few ways in which would-be benefactors would do better than help our Library of which we are so proud.

CARE OF THE PATIENT

Our Society, together with the state hospital association and the two state-wide nursing organizations, has joined to form the Rhode Island Joint Commission for the Improvement of the Care of the Patients. The administrative regulations for this new body are set forth on page 464, in this issue.

The major purpose of the new commission, which incidentally will work closely with the national organization already established, will be to stimulate, implement and sponsor activities that will contribute to the care of the patient. Thus it will seek to create a better public understanding of the various programs of the appointed organizations, their problems faced in coping with the changing aspects of medical care, and the furtherance of studies aimed at better care for the person who is ill and in need of medical and hospital services.

continued on next page

The Commission is not a policy making body. Hence it will achieve its greatest value as a sounding board for a constructive exchange of opinions that may lead to the establishment of more effective programs and policies in the interest of the patient.

This latest action by the major health groups in Rhode Island points anew to the fact that the care of the patient is their primary interest, and they are ready and willing to accept the challenges of the times to improve their programs for that care.

CHANGES IN OASI MUST BE DEBATED OPENLY

On the surface, the Democratic-proposed changes in the Old Age and Survivors Insurance system seem reasonable enough. But so far the public is in no position to look beneath the surface; all the House committee hearings on the amendments were held behind closed doors, with the facts made available only to the committee members on the scene.

In brief, the changes would lower the retirement age for women beneficiaries from 65 to 62, enable disabled workers to collect OASI benefits before reaching the age of 65, bring additional groups under the insurance system, and boost the payroll tax to pay for the added costs involved.

These sound like constructive moves. But is the suggested tax increase (half a percentage point, effective next January) big enough to pay for them? And did the committee fully consider the problems involved in qualifying disabilities and maintaining continuing checks on the status of beneficiaries classed as disabled? That is a much more complicated matter than determining correct age, the only test involved at present for establishing the validity of claims.

Since all the pertinent discussion was secret, the public certainly can't answer these questions. And OASI is, after all, the public's insurance system. How it is manipulated by Congress is of intensely direct concern to every American worker.

No changes in OASI benefits or taxes should be made without full and exhaustive public hearings into the likely consequences. If the House won't hold such hearings, the Senate must.

EDITORIAL

The Evening Bulletin

Providence, Saturday, July 9, 1955

Patronize Journal Advertisers

AMA DELEGATES' REPORT

concluded from page 450

Miscellaneous Actions

Among a large number of actions on a wide variety of subjects, the House of Delegates also:

Commended the *Medic* television program;

Reaffirmed its previous recommendation that the United States withdraw from the International Labor Organization;

Approved the Headquarters Survey Report, which included the statement that "the only public relations program of any permanent value is the private and public relations of the individual doctor";

Expressed regret that the Hoover Commission saw fit to alter or eliminate some of the recommendations of its Medical Task Force;

Reaffirmed its opposition to extension of the Doctor Draft Law;

Recommended the creation of an A.M.A. Committee on Geriatrics;

Warned against the danger embodied in state legislative proposals designed to restrict the entire field of visual care to the profession of optometry.

Election of Officers

The following officers were elected at the closing session, in addition to Dr. Murray, the new president-elect:

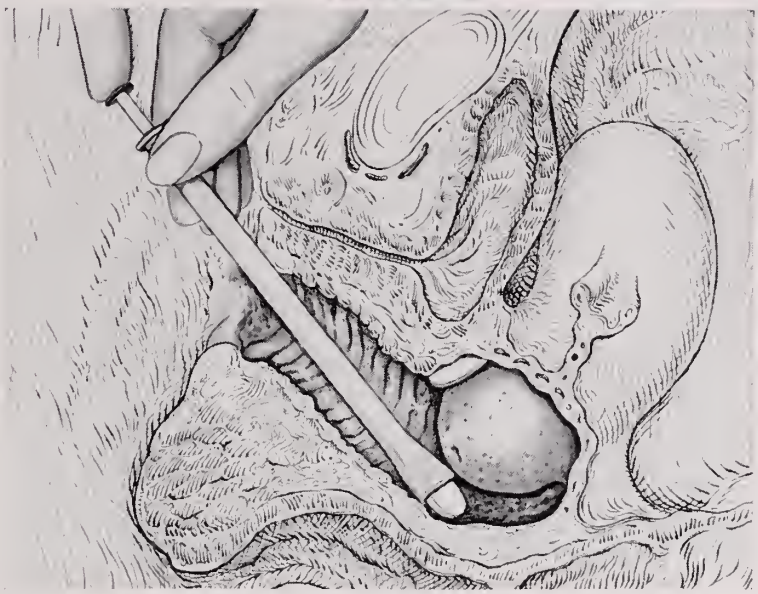
Dr. Millard D. Hill, Raleigh, N. C., vice president; Dr. George F. Lull, Chicago, secretary; Dr. J. J. Moore, Chicago, treasurer; Dr. E. Vincent Askey, Los Angeles, speaker of the House of Delegates, and Dr. Louis M. Orr, Orlando, Fla., vice speaker.

Dr. Gunner Gundersen, La Crosse, Wis., was named chairman of the Board of Trustees to succeed Dr. Murray. Dr. James R. Reuling, Bayside, N. Y., was elected to fill Dr. Murray's term on the board. Reelected as trustees were Dr. L. W. Larson, Bismarck, N. D., and Dr. T. P. Murdock, Meriden, Conn.

Dr. Louis A. Buie, Rochester, Minn., was named by Dr. Hess to succeed himself on the Judicial Council. Elected to the Council on Medical Education and Hospitals were Dr. Harlan English, Danville, Ill., and Dr. James M. Faulkner, Boston, the latter succeeding himself. Reelected to the Council on Medical Service was Dr. H. B. Mulholland, Charlottesville, Va. Elected to the same council were Dr. A. C. Scott, Temple, Tex., and Dr. R. B. Chrisman Jr., replacing Dr. Orr.

Dr. B. E. Pickett Sr., Carrizo Springs, Tex., was reelected to the Council on Constitution and Bylaws, and Dr. Warren Furey was named to the same council to replace Dr. James Stevenson, Tulsa, Okla.

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Treatment with Floraquin tablets may be supplemented with insufflation of Floraquin powder by the physician. Frequency of insufflation is determined by the physician, but is of particular importance immediately following the patient's first menstrual period.

Warm acid douches (2 ounces of 5 per cent acetic acid or white vinegar to 2 quarts of warm water) may be taken as often as desired for hygienic purposes.

Floraquin contains Diodoquin® (diiodohydroxyquinoline, U.S.P.), the safe and effective protozoacide and fungicide. Lactose, anhydrous dextrose and boric acid are included to help restore the normal acid pH of the vaginal secretions. Such an acid vaginal medium then encourages the growth of normal flora and makes the environment unfavorable for pathogens.

A Floraquin applicator is supplied with each box of 50 (a new package size) Floraquin tablets. G. D. Searle & Co., Research in the Service of Medicine.

SEARLE

STATEMENT OF THE COMMITTEE ON MENTAL HEALTH OF THE RHODE ISLAND MEDICAL SOCIETY REGARDING THE FUTURE OF BUTLER HOSPITAL

The committee on Mental Health of the Rhode Island Medical Society, speaking for the Society, has issued the following report regarding the closing of Butler Hospital:

We wish to express deep concern for the future of Butler Hospital, and to volunteer all possible aid to the Corporation and Trustees of the Hospital during the planning for its future functions and structure, if we are asked to do so.

We are aware that it is an unusual procedure for this Committee or this Society to make an official statement regarding a privately endowed Corporation, but we believe it is entirely appropriate for us, and clearly our responsibility, to do so when the issue, as in this case, vitally affects the health and welfare and resources of the entire community, and the specialized training and research potentialities open to the physicians of this community, not to speak of the world-wide medical community, as has been irrefutably the case during decade after decade.

A member of the Board of Trustees of the Hospital has met with this Committee at our invitation, and has freely reviewed the economic problems involved as the trustees have seen them in the past and present, and particularly the several possible functions and plans that can be contemplated for the future.

We believe the proper concern and interest of the medical profession and its state organization extends far beyond the matter of present or future Hospital financial matters.

In our view, Butler Hospital has been one of the few outstanding voluntary psychiatric institutions in the country. Through the years it has functioned not only in offering excellent long-term care for the mentally ill, and active foresighted treatment by psychotherapeutic and other methods, but it has furnished the best of examples in leadership in the development of the American voluntary hospital system. It has set standards for medical practice, it has contributed to the advancement of clinical medicine, providing continuing teaching programs for physicians and it has played a determining role in developing a superlative nursing profession for this and other communities of our country.

All this must not be lost. Today government occupies a large portion of the field which was formerly occupied exclusively by private charity, as exemplified by Butler Hospital, which was the only unit in Rhode Island, when it was established, that cared for the mentally ill. But government-supported hospitals have not equalled the research and teaching programs of the voluntary endowed hospitals.

We believe we recognize many of these issues that have faced the Corporation and Trustees of this hospital. We know that they will explore not only every possibility to continue to augment the services for care of the mentally ill of Rhode Island, but the continuance of leadership in the training of physicians in this most critical specialty of medicine.

Among the possible future plans that we suggest be explored most carefully and imaginatively by the Corporation of Butler Hospital are the establishment of some sort of special unit, preferably in-patient and intensive out-patient in its work, in one of the major general hospitals in the state; the establishment of an in-patient and out-patient therapeutic and training and research hospital for adolescents (which does not really exist as yet in this country or in any other), a rehabilitation and treatment and care center for members of our numerically, vastly increasing aging persons with mental problems. There are many more possibilities. This Committee has no doubt that the combination of wide scope, daring creative imagination and thorough, careful, realistic common sense that were necessary to establish the Hospital more than 110 years ago, can be mobilized as effectively again now. We see some valid reasons to assume it possible that a measure of increased knowledge now added to these factors may well allow of an even more firm, and continuing, yet vitally pioneering institution.

Mental Health Committee Members:

Walter E. Campbell, M.D.
Vera M. Behrendt, M.D.
Aurey Fontaine, M.D.
Hugh E. Kiene, M.D.
Maurice W. Laufer, M.D.
Himon Miller, M.D.
John F. Regan, M.D.
Laurence A. Senseman, M.D.
Jacob P. Warren, M.D.
David G. Wright, M.D.
Joseph M. Zucker, M.D.

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WEDNESDAY, SEPTEMBER 7, 1955—9:00 A.M. to 12:00 NOON

PRESIDING: ALBERT H. JACKVONY, M.D.
Surgeon-in-Chief, St. Joseph's Hospital

SYMPOSIUM ON PERIPHERAL VASCULAR DISEASE

Chairman: E. Everett O'Neil, M.D., *Professor of Clinical Surgery, Boston University School of Medicine; Surgeon-in-Chief, Third Surgical Service, Boston City Hosiptal.*

9:30 A.M. POST-TRAUMATIC SYMPATHETIC DYSTROPHY

George F. Miller, M.D., *Associate Professor of Surgery, Boston University School of Medicine.*

10:00 A.M. THROMBOPHLEBITIS: A Study of 748 Cases
John J. Byrne, M.D., *Associate Professor of Surgery, Boston University School of Medicine.*

Intermission

10:45 A.M. SEGMENTAL OCCLUSIONS TREATED WITH RESECTION AND GRAFTING

Stewart Armstrong, M.D., *Instructor in Surgery, Boston University School of Medicine.*

11:15 A.M. A. THE ROLE OF SYMPATHECTOMY IN PERIPHERAL VASCULAR DISEASE

B. SUMMARY

E. Everett O'Neil, M.D., *Professor of Clinical Surgery, Boston University School of Medicine.*

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EDUCATION DISCOVERS MENTAL HEALTH

continued from page 442

President Dickey of Dartmouth stated in his recent ATLANTIC MONTHLY article,[2] "To create the power of competence without creating a corresponding sense of moral direction to guide the use of that power is bad education." M.I.T.'s President Killian in a recent commencement address put it even more bluntly when he said, "Knowledge without virtue is dangerous."

In this attempt to include the understanding of the emotions as a part of the educational process itself we are introducing something almost revolutionary and at the same time bringing up a problem which man has been trying to solve for centuries. Of course, educated man has always striven for emotional maturity. The Bible and other religious books, famous works of literature, and masterpieces of art and music, all attest in one way or another man's struggle to achieve harmony from disharmony, strength from weakness, beauty from ugliness, order from chaos. The revolutionary part arises from the fact that sufficient information about the nature and role of the emotions has been developed in the last century to upset many of our traditional practices and ways of thinking. Our defense thus far, with some encouraging exceptions, has been to pretend that the whole problem does not exist, that somehow or other unconscious wishes and strivings can be ignored or denied, or if admitted at all, that they are immoral. Knowledge of self, always a prime desideratum, now becomes a more complicated process than it once was, but an even more urgent one.

I should like to state at this time that I do not consider emotional maturity as something separate and distinct from intellectual maturity. Both qualities are fused in the mature person, and only the disparity between the two components permits a separate use of the term in this essay. Charles Curtis was hinting at one of the qualities of a mature person when he referred to "some talent which the expert in a special field lacks when he talks nonsense outside of it and which enables the man who is not a specialist, and knows he's not, to make sense about what he knows little about."[3]

The emotionally mature person is one who respects people and life, even in the face of behavior and events which sorely try his patience. He has achieved that maturity by working through and discarding stages of thought, feeling and behavior that were appropriate or at least expected, at younger stages, but are no longer so. He thus becomes less likely to return to childish behavior when under stress. He is largely other-person-centered in his basic attitudes, getting pleasure in large part from serving others and in their subsequent esteem. He gives more than he receives, redressing the balance of his earlier years when he had to receive more than he gave. He is parental or creative in his dealings with others, seeing or looking for possibilities of growth or betterment in them. He can both give and receive love and affection. He is not ashamed of his emotions, trying to direct or control their expression in action rather than denying their existence. He is able to work without being inhibited by emotional tensions and can meet stresses without disabling bodily symptoms or disintegration of behavior. He does not base his actions on wishful thinking. He does not make those sick who work or live with him. He accepts sexuality as something akin to all those forces and influences which make life meaningful, and, therefore, does not have to exaggerate it constantly. A sense of humor permeates all his activities, along with a sense of humility and a willingness to admit of something bigger than man can comprehend. He has a philosophy to cope with frustration and defeat, such as Churchill exhibited when he said after a peculiarly damaging series of air raids on London, "Let us . . . brace ourselves to our duties, and so bear ourselves . . . that, if the British Empire and its Commonwealth last for a thousand years, men will still say, 'This was their finest hour.' " Or as Albert Schweitzer says, "Anyone who proposes to do good must not expect people to roll stones out of his way, but must accept his lot calmly if they even roll a few more upon it."[4]

No individual ever succeeds in achieving this desirable state any more than he becomes completely educated or attains perfection in any area of endeavor. It remains an ideal toward which he may strive. He can only try again when he fails to live up to the expectations of himself and others.

So far as education is concerned the difficult problem of imparting facility in this field is that for the most part it must be done indirectly. A person may know all about the structure of the personality, how it is developed, how it disintegrates, how peo-

concluded on page 462

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EDUCATION DISCOVERS MENTAL HEALTH

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ple tend to relate to one another, and yet be unable to handle himself effectively in times of stress. He may behave just as if he did not have the theoretical knowledge. Yet this is not to say that the knowledge is not desirable or even necessary. It does mean that learning to conduct one's self with credit, satisfaction, and effectiveness is enormously complicated and that exposure to and identification with persons who are emotionally mature is probably the most effective educational device we have. It puts as much emphasis on what the teacher *is* as it does on what he *knows*.

Group conferences of various types, sometimes with students, sometimes with other faculty members, form the ideal type of in-service training. Techniques for adapting this method to general use are being tried out in various colleges, a central idea being that no scheme can be successful unless the faculty members themselves become aware of the need and the problem and organize a program to fit their own situations.

From this very rapid and quite superficial survey of the field of college mental health it is obvious that the field is just being mapped out, that its cultivation is as yet slight, that the potentialities are indeed great, and that the things that can be learned in developing mental health in our colleges and schools are applicable to society generally. Colleges can develop good mental health in their students by practicing it, both in official activities and in terms of the individual lives of their members. As we observe a general increase in interest in mental health in the nation and in the world generally, we should hope that leaders in the movement toward self-knowledge and self-control may be developed in large numbers in our colleges.

Doctor Ruggles, I regret that your high hopes for the college mental health movement in its very early days have not as yet been fulfilled. I am glad that more and more of our educators are beginning to appreciate and understand what you have been practicing and preaching all these years. Doctor Alan Gregg once said that the crowning glory of the human being is that he is immature a long time, thus enabling him to incorporate in his developing mind a large number of skills and attributes designed to heighten his powers of adaptation. College mental health is still immature, it is growing slowly, but it is developing sound concepts and bases for future development. I hope that when someone reports on the state of this activity in another three decades, the growth of both interest and accomplishment will have been by geometric and not arithmetical progression.

References

[1]Hopkins, M.: Miscellaneous Essays and Discourses, T. R. Marvin, Boston, 1847, pp. 232-255 (514 pages)

[2]Dickey, J. S.: "Conscience and the Undergraduate," The Atlantic Monthly, April, 1955, pp. 31-35

[3]Curtis, C. P.: It's Your Law, Harvard University Press, Cambridge, 1954, p. 38

[4]Schweitzer, A.: Out of My Life and Thought, Henry Holt & Company, 1949, p. 112



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ADMINISTRATIVE REGULATIONS FOR THE RHODE ISLAND JOINT COMMISSION FOR THE IMPROVEMENT OF THE CARE OF THE PATIENT

(Adopted in April, 1955)

I. *The name* of this organization shall be the "Rhode Island Joint Commission for the Improvement of the Care of the Patient."

II. *Purposes and Objectives.* The major purpose of this commission is to stimulate, implement, assist in, and sponsor activities which will contribute to the care of the patient as may be mutually satisfactory to the appointing organizations.

To achieve this objective, the commission performs as a service agency to the parent organizations. It shall be the intention of the commission to obtain a better understanding of the problems and programs of all represented groups; to serve as a source of information on trends within the programs of the participating organizations; to facilitate the development of a more unified public relations approach by the participating organizations; to explore the needs for and stimulate studies in areas of patient care in which the organizations participate; and to perform such functions and carry on such activities contributing to the major objectives as may be mutually satisfactory to the appointing organizations and to the commission.

III. *Membership.*

A. The appointing organizations shall consist of the Rhode Island Medical Society, the Hospital Association of Rhode Island, the Rhode Island State Nurses' Association, and Rhode Island League for Nursing.

B. The *appointed membership* shall consist of four members from the Rhode Island Medical Society, four members from the Hospital Association of Rhode Island, two members from the Rhode Island State Nurses' Association, and two members from the Rhode Island League for Nursing.

IV. *Authority for Appointment*—Each of the parent organiations shall have authority to appoint representatives in accordance with Sections III and V. The four organizations shall be known as the *appointed organizations.*

V. *Terms of Appointment.* Each appointment shall be for three years.

VI. *Voting Privileges and Quorum.* Only appointed members present shall have a vote, except that in the absence of an appointed member a designated alternate of the appointing group shall have the power to vote. *A decision shall be reached by a majority vote.*

A quorum shall consist of seven voting members providing all of the appointing organizations shall be represented.

VII. *Officers.* There shall be a chairman, vice-chairman, and a secretary.

The chairman shall be elected for a one-year term at the annual meeting and may be re-elected for one additional term. He shall take office the following January 1.

The vice-chairman shall be elected in the same manner and at the same meeting as the chairman and may be re-elected for one term.

The secretary shall be a member of the Commission. He shall be elected for a term of two years.

The chairman shall preside at meetings and perform the usual functions of presidents of similar organizations. The secretary shall perform the functions customary for that position in similar organizations.

VIII. *Meetings.* There shall be at least two regular meetings annually. The first regular meeting of the year will be the annual meeting. Special meetings may be called by the chairman.

Attendance at meetings shall be limited to appointed members, alternate members and other individuals who may be invited by the chairman to participate in the program, or whose presence may be requested by one of the appointing organizations and approved by the chairman.

IX. *Committees.* There shall be an Executive Committee of four members consisting of the chairman, vice-chairman and one other elected annually at the annual meeting to represent the third group, and the secretary *ex-officio.* Vacancies may be filled by the chairman from the group represented.

The Executive Committee shall carry on the activities of the commission between commission meetings. Other committees may be appointed by the chairman.

X. *Financing.* The expenses of representatives shall be a responsibility of the respective appointing organization.

Other organizational expenses, such as those for clerical service, meeting space and office work, shall be divided equally between the three major groups (nursing, medicine, and hospitals).

XI. *Relationship of the Commission to Appointing Organizations.* The commission shall be a service group to the organizations represented. It shall be a sounding board for a constructive exchange of opinions. Actions of the commission are advisory to and not mandatory on the appointing organizations. The commission may originate actions for consideration by, or may receive actions for consideration from the appointing organizations. The Rhode Island Joint Commission will keep in touch with the National Joint Commission for the Improvement of the Care of the Patient, ask for help and advice as necessary, make suggestions and recommendations and submit an annual report to the National Commission.

The failure of an appointing organization to approve or disapprove a commission conclusion within a period of three months shall be accepted as approved in principle. An extension of three months will be granted on request.

Such items as are unanimously approved by the commission and deemed suitable for publication by all four presidents or by all four executive secretaries of the appointing organizations may be released by the Rhode Island Joint Commission to the public through professional and other media.

XII. *Amendments.* These rules may be amended without previous notice by unanimous vote, or by a two-thirds vote, if the amendment has been presented to the membership of the commission at least two weeks in advance of the meeting at which the vote is taken.

XIII. These rules and/or amendments shall become effective when approved by the commission and appointing organizations.

XIV. Deliberations of all meetings of the commission shall be governed by Robert's Rules of Order, Revised.

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OBSERVATIONS ON SOME OF THE NEWER DRUGS

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about because of a failure to comprehend the exact mechanism of action of this drug. Therefore, I thought in view of the recent information which has been worked out concerning the action of this drug that it would be of interest to briefly discuss its metabolism in the body.

When ammonium chloride is absorbed the ammonium moiety is immediately converted into urea by the liver, thus releasing chloride ion which is immediately combined with bicarbonate base to form a sodium chloride. The excess sodium chloride along with isosmotic quantities of water is then excreted by the kidney and an excellent diuresis results. Unfortunately, this leads to rapid loss of sodium base, which then brings about a shift in pH and a decrease in bicarbonate base as the glomerular filtrate is presented to the tubule cell. The kidney immediately sets about correcting this situation. In order to prevent acidosis it synthesizes ammonia to which is added hydrogen ion to form ammonium which is then combined with chloride, and the resultant ammonium chloride is excreted in the urine. When this occurs, usually three to four days after ammonium chloride has been given, all diuretic action is lost.[19] A normal kidney under adequate stimulus can, for example, produce as much as 7 grams of ammonium in twenty-four hours. This is adequate to handle the excess chloride from very large doses of ammonium chloride. It is because there is a lag in the synthesis of ammonium that oral ammonium chloride can exert its diuretic effect, but since this ammonium synthetic mechanism comes into play rapidly, the diuretic effect of ammonium chloride for the most part passes off within a period of three or four days and, therefore, is not effective until the ammonium synthesizing function of the kidney is again suppressed.[20] It should, therefore, be obvious that the use of ammonium chloride as a diuretic agent should be restricted to periods of three to four days followed by rest periods of three to four days rather than continuous administration. It is furthermore apparent that if there is severe damage to the kidney and the ammonium synthesizing function is lost the ammonium chloride taken by mouth can then lead to serious drain of sodium and consequently severe acidosis. Furthermore, if there is severe liver impairment and the ammonium cannot be converted into urea, again a toxic situation can arise. Therefore, in order to avoid either an acidosis or severe toxemia from ammonium chloride, the drug should not be given in the presence of serious liver or kidney damage and for best results it should be given in a dose of 4 to 6 grams a day for periods of three to four days and then discontinued for a period of three to four days. Long continued use

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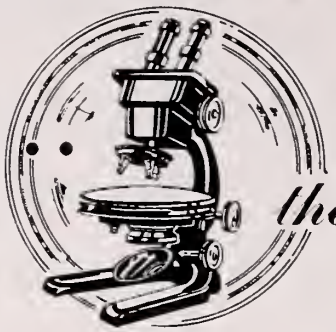
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Based on a representative sample of about forty thousand persons surveyed by the U. S. Bureau of the Census for the National Cancer Institute of the PHS, an estimate has been advanced that approximately thirty-eight million Americans are regular cigarette smokers, but one and one-half million have quit smoking entirely in the last eighteen months. The data will be of value to the Cancer Institute statisticians and physicians who are studying the incidence of cancer in the population, particularly lung cancer, in relationship to smoking habits. A report containing more detailed findings of the survey by the Census Bureau is in preparation, but will not be ready for several months.

FOLSOM SPEAKS ON HEALTH INSURANCE

Marion B. Folsom, formerly under secretary of the Treasury, and the man who played a part in the recent changes in the social security law, took over Mrs. Oveta Hobby's post as secretary of the Department of Health Education and Welfare. The A.M.A. Washington Office reports that at a news conference following his nomination, Mr. Folsom said the present social security law "is in pretty good shape," but that it should be extended to take in professional people and more of the self-employed. He also declared that voluntary health insurance should and could be extended without federal help. He said that he thought the "big thing" for the future would be in major medical care or catastrophic insurance.

LET'S FACE THE FACTS

The Commission on Chronic Illness, in a preview of its long awaited five-year-study report, to be published later, states that family and public unwillingness to face the facts plays a large part in the problem of what to do about the 5,300,000 Americans who have a long-term disability or illness. The commission stated that before the problem can be solved reasons for existing unsatisfactory care of the disabled should be found. The commission's recommendations were concerned with improvements in personnel and education, research and financing.

MEDICAL HORIZONS STARTS SEPTEMBER 12

A new half-hour TV series, titled *Medical Horizons,* presented by Ciba Pharmaceutical Products, Inc. of New Jersey, in cooperation with the American Medical Association, will be premiered on Monday evening, September 12, over ABC-TV. The new documentary series will promote the American way of medical life by presenting specific accomplishments in the field of medicine brought about by the teamwork of modern medical research, education and practice. The program will go on each Monday evening from 9:30 to 10:00 P.M., EST. Preliminary plans call for a Providence station to carry the program locally.

WHAT PRICE NEW AUTOS IN 1956?

Although Ford and General Motors did not sign their lives away with their agreement to pay laid-off workers a guaranteed annual wage, mainly because of protections built into the agreement, they certainly have set the stage for a possible pricing of automobiles beyond the reach of many a family in the next couple of years. The roadblocks in the agreement that will aid the manufacturers temporarily are that the plan dies unless the federal government lets the companies treat as deductible expenses on their income taxes the contributions they put into their funds for laid-off workers; and secondly, the problem that the states containing two-thirds of the Ford and GM workers will have to agree that laid-off workers can collect both pay from the companies and full unemployment insurance given by the states. Our guess is that both roadblocks will be lifted by June, 1957, and we'll wager the union officials who cry out against tax

exemptions for industry will tone down their tune in this instance where their own benefits are at stake.

But what is not generally known are the very liberal benefits for insurance and health benefits under the new agreement. Take a look at these:

A $13 weekly increase for the worker temporarily disabled who has a basic hourly rate of $2.

An average of about $52.80 weekly in sickness and accident benefits, payable from the first day for accidents.

Regardless of age, 26 weeks of benefits payable for any disability.

$5 for each day for medical benefits for in-hospital care for the worker, *spouse and dependent children*, with a maximum of $350.

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Diagnostic X ray and electrocardiograph services provided when worker *or member of his family* is admitted to the hospital. The number of such services is unlimited, and the benefits are the amounts set forth in a schedule maintained by the Blue Shield plan.

Wherever possible, full payment for surgical services for families earning less than $6,000 or single workers earning less than $4,500.

Anyone who has had any experience in the cost of hospital and over-all health care can readily appreciate that the benefits outlined above cannot be classified by anyone in his right mind as "fringe benefits." They represent costly items in the wage agreement effected by the auto industry, and the public will have to pick up the tab every time it decides to invest in one of the rainbow-hued cars that brighten our national landscape.

Oh, yes—there is one consolation. During the war years when we had to make our autos last, General Motors and the other big auto makers proudly informed all of us that their cars were made to last—at least for 100,000 miles. We suspect that many a family will put this boast to full test in the coming years.

BUILD AND BLOOD PRESSURE STUDY

The Committee on Mortality of the Society of Actuaries has announced plans for a 1955 Build and Blood Pressure Study, the first study of mortality in relation to build to be undertaken in more than twenty-five years, and the first investigation of persons with abnormal blood pressure since before World War I. Fifty U. S. and Canadian life insurance companies have been invited to participate in the study which will seek to find out just what effects over weight and high blood pressure have had on longevity in recent years. The analysis will be carried out separately for men and women, and the experience will be checked in relation to

continued on next page

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variations in height, and weight, blood pressure, and with respect to several categories of minor impairments existing at the time such persons were issued life insurance policies.

DOCTOR TEFFT HONORED AT BALTIMORE REUNION

Doctor Benjamin F. Tefft, of West Warwick, eighty years young last May, was honored by the Alumni Association of the University of Maryland, as the medical class of 1905 held its reunion in June. A fifty-year certificate, embossed in gold lettering, was given to the Rhode Island physician for services in his community in upholding the high ideals and standards of the medical profession. Rhode Island has reason to be proud of its roster of outstanding physicians as exemplified by Doctor Tefft.

DILEMMA IMMINENT IN CALIFORNIA

We have had our problems with the local state temporary disability compensation program, but the California physicians, as we view it from across the country, will face a vexing situation with their disabled workers in the coming months as the result of amendments to their state disability insurance law at the recent legislative session.

The trouble arises from the following situation: claimants who receive wages or continuation wages when disabled will also be paid disability insurance, which when added to such wages or continuation wages may go up to their *full weekly wage*, rather than limited to 70 per cent of their weekly wage as was the case until now. The result: a disabled unemployed claimant gets $40 a week, while an able and available unemployed claimant gets $33. Add to this situation the fact that about twenty thousand claimants cannot get unemployment insurance because they have not earned $600, but they can get disability insurance if they have earned $300, and you begin to realize that the California doctors will be hard put to satisfy the claimant who will find it more profitable to convince himself (and try to persuade his physician also) that he is disabled. Looks like another case of where it pays to be sick.

REUNION DAY AT ST. JOSEPH'S

Elsewhere in the JOURNAL is printed the very attractive program for the Reunion Day at St. Joseph's Hospital (see page 458). All local physicians are invited to attend this symposium on peripheral vascular disease, and the St. Joseph staff association is to be complimented in arranging such a splendid scientific session to open the Fall season of medical meetings.

INTERIM MEETING OCTOBER 26

Plans have been completed for the Interim Meeting of the Society to be held on Wednesday, October 26. A scientific program consisting of a symposium on diseases of the colon will be presented at the Medical Library in the afternoon, and a dinner session will be conducted at the Narragansett Hotel in the evening. The Auxiliary plans an afternoon meeting at the hotel. Check the date now . . . *Wednesday, October 26* . . . afternoon and evening.

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OBSERVATIONS ON SOME OF THE NEWER DRUGS

concluded from page 466

with excessive loss of nitrogen through synthesis of ammonia can conceivably lead to lowered serum proteins amino acid nitrogen is utilized by the kidney in the synthesis of ammonia, which is then lost as ammonium chloride.[19]

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BOOK REVIEWS

FLUOROSCOPY IN DIAGNOSTIC ROENTGENOLOGY by Otto Deutschberger, M.D., W. B. Saunders Co., Philadelphia, 1955. $22.00

Greater use of fluoroscopy as a diagnostic tool is the stimulus behind the author's exhaustive review of the uses of fluoroscopy in all fields of medicine.

In a well-written, well-illustrated book of 771 pages and 888 illustrations he has compiled most of the information on the history, physics, equipment, hazards and their control in fluoroscopy. He gives us extensive detail in the clinical application of fluoroscopy in examination of the head, neck, chest including heart, abdomen including gastrointestinal, urinary, and female genital tracts, foreign body localization and reduction of fractures. The chapters of chest and abdomen are almost complete monographs.

Besides general considerations and technics of examination, many of the methods and "tricks of trade" for eliciting signs of disease are outlined. The bibliography and index are excellent.

The book is not entirely without criticism. At the beginning one gets the impression that the author is trying to utilize fluoroscopy almost to the exclusion of radiology (even though he does not say so), or at least use fluoroscopy preponderantly. As one goes deeper into the book, it is found that whole sections deal with descriptions of a disease entity at the end of which it is said that fluoroscopy has no special value. While the description of these diseases is valuable as such, one might question whether this serves any useful purpose. Most of the radiological illustrations show advanced processes which are easily diagnostic by X ray alone. Here again it is felt that illustrations showing early lesions where fluoroscopy helped direct the radiological examination would serve a better purpose.

The author tends to minimize the "alleged disadvantages of fluoroscopy" viz., "that fluoroscopy is frequently considered dangerous to the health of the patient and physician and that it is time-consuming." Many radiologists would not agree that these are only "alleged disadvantages" and the author himself uses the entire next chapter to describe the hazards of fluoroscopy and methods of reducing these hazards. Unfortunately lack of knowledge, inertia, old equipment without modern safeguards are still too widely extant. Readers of Dr. Deutschberger's book will learn much in methods of testing and correcting deficiencies in equipment and in fluoroscopic manipulation.

The actual disadvantages of fluoroscopy, namely its inferior definition of outline, lack of permanent images for reference for either present or future needs, lack of brightness of image, and very importantly, actual fatigue to the fluoroscopist represent definite limitations. It is still felt that radiography supplemented by fluoroscopy as indicated clinically, and perhaps by preliminary films is perhaps the optimum method of handling patients.

It should be brought out that the newer equipment with its remarkable fluoroscopic image amplification now becoming available, will enlarge the scope of the fluoroscopist because of the much easier visualization of image and less fatigue to the examiner and with less danger of radiation injury. The cost of the image amplifier and some limitations of size of the fluoroscopic field at present limits its use, but these disadvantages will probably be overcome in the future.

The author has presented a book with a forward look to the time when image amplification will allow for even more extensive fluoroscopic examinations, with a present look to make us more expert in fluoroscopy and therefore, add a valuable tool to our diagnostic skill. He is to be commended on a valuable book both for the specialist and the general practitioner.

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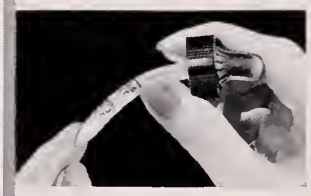
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INTERIM MEETING — OCTOBER 26

See page 508



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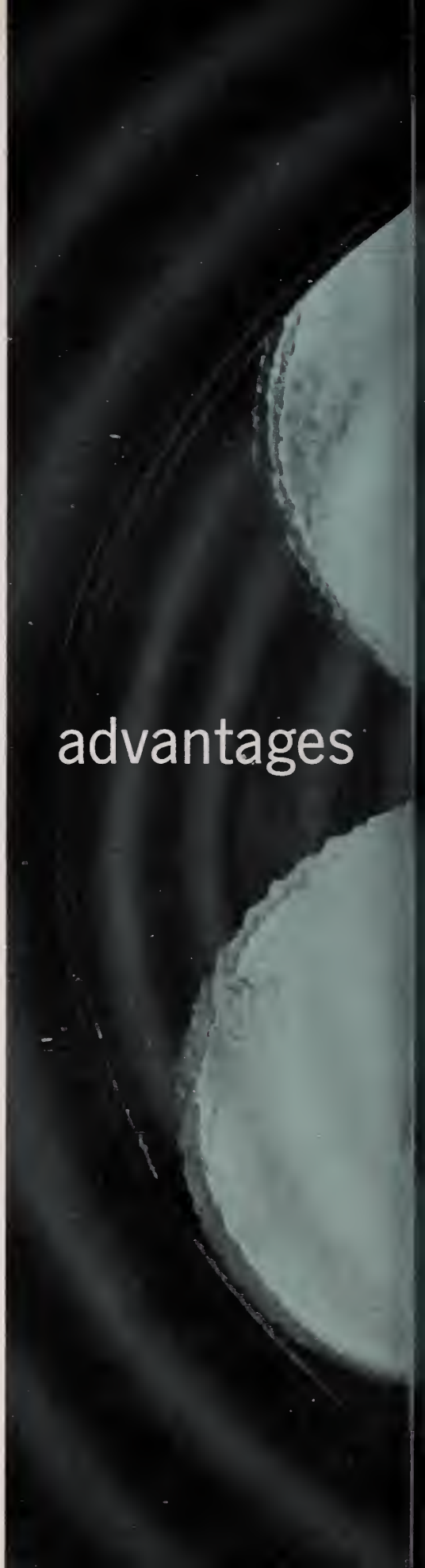
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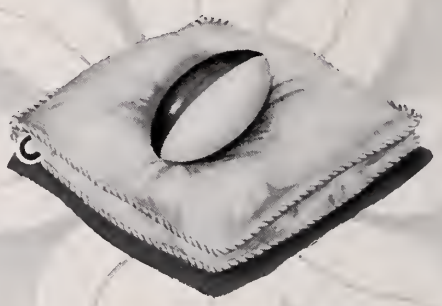
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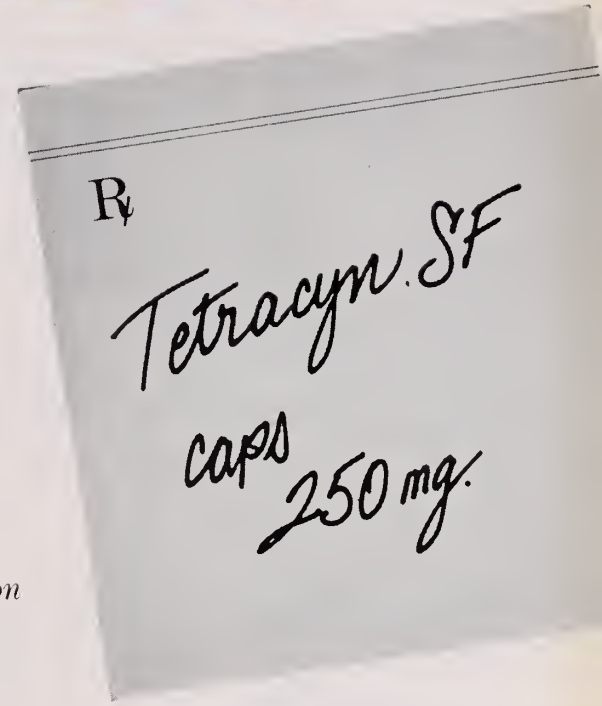
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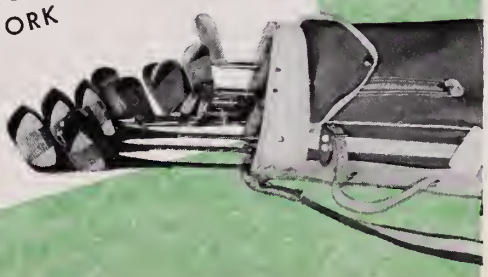
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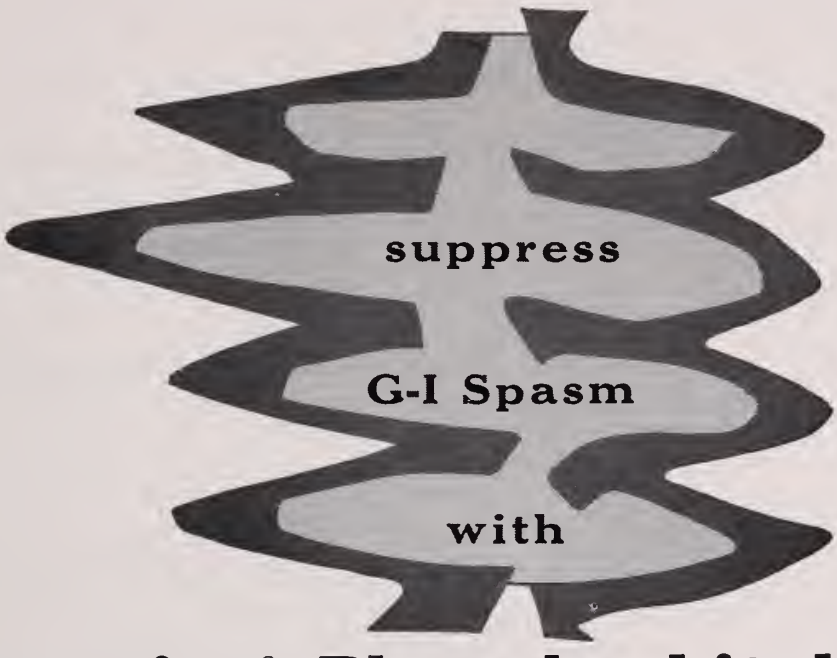
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1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* **19**:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* **14**:323, May 1950.

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The RHODE ISLAND MEDICAL JOURNAL

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THE ADOLESCENT'S PERSONALITY: IMPLICATIONS FOR TREATMENT*

J. ROSWELL GALLAGHER, M.D.

The Author. *J. Roswell Gallagher, M.D., of Boston, Massachusetts. Chief, the Adolescent Unit, Children's Medical Center; Assistant Clinical Professor of Pediatrics, Harvard Medical School; Author of "Understanding Your Son's Adolescence."*

SALLY WAS referred to our clinic for the management of what was said to be cardiovascular disease associated with tachycardia and hypertension. At examinations during the previous year she consistently had been found to have a heart rate of about 120 and a blood pressure of 150/90. There was nothing in this fourteen-year-old girl's history to suggest a familial, congenital or infectious cause of heart disease. She had no symptoms except palpitation and eye fatigue: it was the latter that had made her mother ask for a "check-up." There were no significant findings on physical examination, in the electrocardiogram, or on fluoroscopy of her heart. Nevertheless, on the basis of her blood pressure and pulse level, she had been told to give up all forms of exercise, and had been told she should "take it easy" all summer.

The following autumn, at her initial visit to us, Sally impressed her physician as being a healthy, strong, young person who would be quite attractive were she to lose her obvious air of resentment, suspicion and worry. Her physical examination and all the laboratory findings were in agreement with those reported at the time of her referral; but her pulse recovery after strenuous exertion was good, and neither her general appearance nor the findings seemed to us to justify a diagnosis of cardiovascular disease or to demand a restriction of her activities. As a matter of fact her physician's suspicion that other than structural changes were responsible for her borderline findings began as he formed an impression of her personality, and increased as she told him things about herself, about her family, her friends, her daily life, plans, and her worries.

Sally's father, whom she adored, had been a fine athlete; she had always wanted to please him, to excel in athletics and become a physical education teacher. School work interested her very little. She wanted to be sure that studying wouldn't hurt her eyes, and the reading which the longer high school assignments required clearly worried her. She wasn't at all nervous at softball, in field hockey, or in a swimming meet, but she said, "My heart pounds when I have to give a talk in school." Her menarche the previous spring was a real blow: "Sure, I always wanted to be a boy."

There were enough hints here for anyone familiar with an adolescent's attachment to a parent, their hero worship, their resentment of anything that pushes them around, their frustration and worry when faced with something beyond their control and contrary to their hopes. Success, a career in athletics, was everything; becoming a woman was less than nothing. School work made her (eyes) tired, to talk in front of boys made her heart pound, and her periods "cramped her style." "I just got to worrying, — everything seemed wrong; boys never used to bother me, — nothing was working out right, and I just knew that the doctor would find something wrong and really spoil it all, and he did."

A big tomboy now, but still worshiping her father, and alternately envying boys and being conscious of them, she needed a chance to work out this confusion and to have unobtrusive support and understanding while she was making the transition to a more feminine approach to life. These she needed; and these, by paying attention to *her* and not to her heart rate, relieved them both.

It is not enough to know diseases, their causes, symptoms and treatment. It is equally important to know the person who has the disease, to know his or her characteristics, attitudes, needs and worries. These affect, and may even cause the symp-

continued on next page

*From the Adolescent Unit, The Children's Hospital, Boston; Studies upon which this material is based have been supported by The Grant Foundation, Inc. Address presented at the Annual Meeting of School Physicians of Rhode Island, at Providence, R. I., May 4, 1955.

toms; they will modify the ailment's course. They obviously should strongly influence our thinking in making the diagnosis, and in choosing the method of treatment.

This is of course the proper way to regard all illness and all patients. But it is imperative in the management and treatment of adolescents. There is no other age group whose care furnishes so good an opportunity to supplement one's training in medical thinking with practice in being thoughtful. An adolescent's nature forces this opportunity on us. No other age group so insistently demands that you pay attention to the person as well as to the ailment. This stems from one of the adolescent's outstanding personality traits: their unyielding over-concern with themselves. They are so intent on developing their own personalities and so alert to any efforts to force them into a mold, that it is impossible effectively to deal with them unless one recognizes this and pays just as much attention to *them* as one does to their symptoms. The adolescent so keenly feels the need to become himself, to develop his own personality, that he instinctively resists any suggestion which he feels will either warp, or threat, or thwart his own development, or any move which he feels may impose your will on his. Though they are intent on protecting themselves, they vacillate in their capacity to be independent and to be themselves and therefore, often behave in a blustering fashion characteristic of insecure people of all ages. In caring for them we need to remember that they are more aware of themselves than an adult, and less able to compromise.

In the Adolescent Unit general practitioners, internists and pediatricians all work together caring for those young people who come to them for help with their lame backs, their indigestion, their cramps, their heart trouble, but the emphasis is just as much on helping and understanding the person as it is on treating the symptom or the disease. The Adolescent Unit's major interest is the development of physicians' understanding of adolescents' personalities and of their skill in managing their psychosomatic disorders. Each physician in the Unit is assigned to a psychiatrist who acts as teacher and supervisor for all problems in diagnosis, management and psychodynamics which any patient presents. Every effort is made to teach these physicians how to approach patient care from the psychodynamic point of view, to recognize and treat minor emotional problems; to recognize those emotional patterns which require a psychiatrist's skillful management, and to appreciate the emotional component that is part of every organic disorder.

In order that we may elicit the information we need and build the best sort of physician-patient relationship, we treat these young people in a different manner than one usually treats little children. We give them a place which is exclusively theirs, where there are neither little children nor adults as patients. We see their parents first, and preferably on a previous day so that a boy or girl will not be kept waiting while his parents talk. We see the boy or girl alone so that they may talk confidentially. We discuss our findings and possible ways of handling the situation with them. And we discuss school, their interests, and their relationships as well as matters which might seem to be more intimately related to the presenting problem. Basically we are sincerely trying to get to know this person and to make him feel that we are as interested in him as we are in his problem.

It is our aim to have the general practitioners, pediatricians and internists working in the Unit gain both an intellectual concept of emotions as they relate to general medicine and to acquire those techniques of psychotherapy which they can use daily in the practice of medicine. Increased knowledge of the personality development of the adolescent enables the physician to utilize it in handling all his patients whether they have a purely emotional disturbance, a physical ailment or a mixture of the two. As we all know, a doctor-patient relationship becomes more and more effective as a physician acquires this psychotherapeutic attitude and learns to understand his patient as a person and not merely as a problem in diagnosis and treatment. We feel that such an approach is desirable with all patients and that it is essential if one is to be successful with adolescents.

As a basis for understanding adolescents one must know something of their physical characteristics. Admittedly, and this is important always to remember, they differ widely from one another, but they all follow the same general pattern of development and have for the most part similar needs and problems. No one matter is of more interest and concern to them, or more frequently affects their happiness and behavior, than their bodies. Therefore, facts about growth and development during this age period are important to know.

Little children and adults have slight emotional concern with their size. An eight-year-old child does not care how tall or mature he is, and a thirty-year-old adult does not as a rule become emotionally upset by the fact that his height is greater or lesser than his neighbor's. The adolescent, however, feels differently about the matter. Height, weight, and state of maturity all mean a great deal during these years. The adolescent who is not maturing as rapidly as his or her companions, the boy who is shorter, or the girl who is taller or more obese than usual, not only dislikes being different but may become emotionally upset fearing that she will keep on getting taller or that he or she will never mature.

Some of this over-concern with their own growth and size is due to adolescents' conservatism, to their desire to be like their associates. Some of it arises out of the fact that size is a factor in their athletics, in their social success, and in their acceptance by their own age group. Some of it develops because for years their parents, teachers, and physicians have expressed such great interest in their growth and have compared them to charts and to standards which children accept unquestionably and yet fail to understand or misinterpret. At times their over-concern and anxiety arises because they suspect that their masturbation in which they guiltily persist may be adversely affecting them.

Few adolescents are aware that wide variation from the average is compatible with normality: to most of them to vary from what is average is to be abnormal. They need to have some knowledge of average patterns of growth and to understand the fact that a variety of different states and rates of growth and development are normal.

Just as their bodies develop and change so do adolescents' interests and attitudes. When an adolescent was a baby his crib measured the limits of his world. Next his play pen, later his back yard and his own home held all he had to understand. Then, a boy, he entered that wonderful carefree time of climbing fences, teasing girls, collecting everything, rising early, yelling, and chasing cats—a time of shyness, despising soap, stuffed pockets, and insatiable appetite. Now he is an adolescent. Soap and girls are no longer ignored, a trouser crease is more important than a bulging pocket, his ten thumbs and tripping feet show intermittent promise of coordination; he sleeps late, and only when off guard or with his group shouts or lets himself go. A tennis racket has replaced the slingshot, and a football the raucous "cops and robbers." Those are the little changes. The major ones are his wanting to be grown-up, his striving for acceptance by his group and for prestige, his rebellion against authority, his negating of his family and his loyalty to his gang, his idealism and his questioning of what he used to accept on faith, his interest in sex. And yet the adolescent's striving, his interests and his rebellion vacillate. He will let his first "glamorous date" wait while he shows an old friend a new rifle, and he will fear at the end of a hard-fought struggle for independence to accept the freedom and responsibility he has won.

Much of the turbulence of adolescence comes from their confusion over which parent to model their behavior on, with which to identify, just as was true of Sally. It would seem a simple matter of boys following father, and girls, their mother, but this matter of identification with the appropriate parent is one of the more disturbing processes of adolescence.

Adolescents become upset by matters that less frequently disturb younger or older people. In early adolescence they do not transplant well; they miss the old places and their old friends and find making new friends difficult. It is a time when they badly need to be accepted: they are breaking away from their parents, so increasingly turn for support from "their gang." Religion, an upset home (it doesn't take a divorce to do it), death, fallen heroes, sex, and the behavior of adults in general, confuse and disturb them, and they become disturbed in their efforts to become grown-up and independent. They need success, friends, and acceptance. They need strong, stable, warm adults to turn to, to imitate, and for support, but not for dominance. They need praise as much as they need censure.

Rebellion is characteristic of young people who find the transition from utter dependence to independence so difficult. It is so annoying that we all have to remind ourselves at times that conformity and attendant dependency, though less apt to disturb the peace, may in reality at times be less desirable and promise little but trouble for the rough days of adulthood which lie ahead. The adolescent's imperative need to achieve independence and the importance of fostering the gradual evolution of his behavior from the utter dependency of infancy toward the complete independence of adulthood cannot be overemphasized. As young people grow up, they should have increasing opportunities to venture and to become independent: these they now need as they formerly needed constant protection and support. To continue to protect them, to continually thwart their attempts to develop independence is to rob them of the strength they will need.

During these years of beginning to be an adult, which is what adolescence really is, young people are breaking away from their parents and turning away from home. They want to be, and they should become, independent. But as they vacillate between dependence and independence, and alternately lean on, cling to, and reject their parents and their gangs, so also do they turn to and imitate other adults. With these there are no close emotional ties, there is no embarrassment, it is easier to talk. This gives all physicians who care for them an opportunity which should not be lost. The physician who understands adolescence and who is able to detect and treat minor emotional problems is in a position to do something at their onset: the time we all know they are most effectively helped.

Billy was brought into our Unit because he was stealing money, staying away from home until the early hours of the morning, and being truant from school. His mother said that his behavior had become increasingly rebellious over the past six years. He was the only child of parents who were divorced

continued on next page

when he was two and a half years old, and had been brought up by his mother.

At his first visit this twelve-year-old boy was extremely rebellious and demanding. He said that the only thing he wanted was a black leather jacket. "That's all I want." He talked about his stealing episodes, said that he just didn't know why he did these things, and spoke with much emotion of his mother's continual nagging and criticism. Billy talked, too, about his father, and ventured the opinion that his father was timid and drank too much. Toward the end of the visit he repeated his wish for a black leather jacket, and said he also wanted to be sixteen years old and to own a car.

As a rule the patient and his mother are seen together at the end of the initial interview. At this one there was a very unpleasant scene in which Billy was rebellious and resentful and made imperious and violent demands on his mother. His allowance wasn't enough; he couldn't go to the movies in town often enough; she wouldn't give him a black leather jacket. "Doctor, why don't you force her to give me a black leather jacket?"

Billy was subsequently seen several times within a month. During this time his behavior changed rapidly. He became talkative and friendly; and since his school was nearby, he would often drop into the Unit just to get a drink of water or come in to talk for only a few minutes. He has been seen approximately at monthly intervals for the past year and a half in this unusual fashion. There has been no unacceptable behavior, his school work is excellent, and the report from his summer camp was extremely complimentary.

Billy, like many an upset adolescent, was hungry to find a stable adult whom he could admire, imitate a little, lean on when necessary. Lacking a strong father he was confused about the business of growing up to be a man, and concurrently had to reject any tendency to be feminine by trampling on his mother. When such a boy fastens himself on an understanding physician, his behavior can change in a very gratifying manner.

Not all emotional disorders in adolescents respond promptly to short-term psychotherapy. This age group has its quota of schizophrenias, anorexia nervosas, and other grave psychopathies that require treatment by specialists. But many emotional disturbances whether alone or concomitant with an organic disease are amenable to treatment by the general practitioner, pediatrician and internist who has had some special training. Experience and training in the management of these minor emotional illnesses also familiarize the physician with the nature of adolescents' disturbances so that when he meets a more serious mental disorder he is far more likely to recognize it as requiring intensive treatment.

It is perhaps hardly necessary to state that we do not consider that these young people have been "cured." But they have been helped sufficiently so that they can lead effective lives. That goal may seem to some short of desirable, but we would not agree.

Sally's story illustrated the fact that a strictly medical approach can fail to help the patient, and Billy's how readily some adolescents respond and how their tendency to imitate and fasten upon a stable, warm adult can be utilized. Adolescents, however, will be best cared for when a knowledge of the personality is combined with a thorough knowledge of their physical ailments. It can be just as disastrous to focus upon a patient's emotions as it is to confine one's thoughts to what are sometimes unfortunately regarded as "strictly physical" illnesses.

Edith complained of nervousness, fatigue, inability to sleep, and recent failure in school. Her mother had taken this sixteen-year-old girl to several psychologists because she believed her symptoms were psychological in origin. Their findings showed that hostility toward her mother, and her mother's recent hospitalization for a ruptured disc were responsible for her present symptoms. They recommended psychotherapy.

Our patient was tall, attractive, and alert. She talked freely and without tension. Though she seemed to believe she had many things the matter with her, her manner of talking about them was that typical of a well-adjusted girl and not at all that of a neurotic person. Her interpersonal relationships seemed satisfactory, and her general demeanor seemed inconsistent with a psychosomatic disorder.

Her physical appearance, however, produced an impression in striking contrast to that gained of her personality, and subsequently her physical examination and her laboratory tests confirmed the initial clinical impression of hyperthyroidism. In this instance, had the physician not been familiar with adolescents, or had disregarded the emotional and physical aspects of his patient's disability, he might very well have overlooked the inconsistencies between the patient's behavior and her symptoms.

Edith's story clearly indicates that a knowledge of the adolescent's personality and a due regard for both the physical and the emotional factors in illness and the relationship between them are essential if one is to avoid erroneous diagnoses and unsuitable treatment.

It is at times a problem to get an adolescent to visit a clinic or a physician: even more frequently it is difficult to get him to accept help from a psychiatrist. In a medical clinic we have at our disposal a greater number of maneuvers which serve as rea-

concluded on page 506

RECOGNITION OF INJURIES TO THE LOWER END OF THE COMMON DUCT

ANTHONY V. MIGLIACCIO, M.D.

The Author, *Anthony V. Migliaccio, M.D., of Providence, R. I. Surgeon, Rhode Island Hospital.*

THE RECOGNITION of injury to the intrapancreatic portion of the common duct during manipulative procedures has been speculative. Rarely, does one hear it mentioned in the literature or in the operating room. This is in sharp contrast to what is known and written about injuries to the suprapancreatic portions of the common duct.

Recently, while trying to evaluate the condition of a common duct by the use of the Methylene Blue technique.[1] it was noted that the entire region behind and to the right of the duodenum had become discolored.

The presence of a false passage was thus recognized and another useful addition to the surgical armamentarium was established.

Case History

Mr. M. DiC., age 52 (RIH #533600) was admitted to the Rhode Island Hospital on October 6, 1954, because of recurrent attacks of gallstone colic and several bouts of jaundice. He had been studied by both the Lahey Clinic and a local roentgenologist.

Following admission, a cholecystectomy and choledochotomy were performed. During the operative procedure, it was noted that the head of the pancreas was markedly indurated. This made palpation and exploration of the lower end of the common duct unsatisfactory.

Number three and four Bake dilators were readily and easily passed. The number five and number six dilators were missing from the setup. Rather than jump from a number four to a number seven, I decided to insert a catheter and inject Methylene Blue, in order to put this technique to the test.

When the Blue was injected, no dye could be recovered from the Levine tube lying in the duodenum. The retractors were removed and it was noted that the entire retroduodenal area was discolored.

It was decided to be conservative and to insert a T-tube into the common duct. The gall bladder had been removed previous to the exploration of the common duct.

The postoperative course was benign and the temperature never went over 100. A cholangiogram, taken on the tenth postoperative day, was normal and showed no evidence of residual stones or extravasation.

The patient was discharged on his eleventh postoperative day and the T-tube was removed in my office on the twenty-first postoperative day.

Having established the fact that a false passage is present, one is then confronted with the question of whether further manipulations should be carried out. It is quite probable that transduodenal exploration of the lower end of the common duct or further intraductal manipulations of the distal segment will only serve to aggravate the existing trauma and, because of this, one should consider seriously whether it would not be wiser to terminate the procedure for the time being.

The dangers of continuing the exploration in the presence of a false passage lie in the fact that further manipulation will, in all probability, increase the trauma and therefore allow for the escape of a large amount of bile and pancreatic secretion into the retroduodenal area. The chemical reaction, thus initiated can be responsible for extensive retroperitoneal fat necrosis with its inevitable associated toxemia.

In contrast, if T-tube drainage is resorted to without increasing the amount of damage, then time will heal the injured common duct, thus avoiding extensive edema, infection and prolonged spasm of the sphincter of Oddi. The absence of these will make the handling of the obstructing calculus easier at a later date and at times we may be astonished to learn that the obstruction was probably due to infection and edema and not to a calculus at all.

SUMMARY

The Methylene Blue technique offers us a new method of ascertaining the presence or absence of a false passage in the common duct.

After a false passage has been created and recognized, one must consider terminating further manipulation in order to avoid more extensive injury to the common duct.

REFERENCE

[1] Migliaccio & Dziob: A Simple Test to Determine the Patency of the Common Duct, Surgery, Vol. 36, No. 5, P. 953, Nov., 1954

THE BEGINNINGS OF MEDICAL EDUCATION IN RHODE ISLAND

Part I

SEEBERT J. GOLDOWSKY, M.D.

The Author, *Seebert J. Goldowsky, M.D., Surgeon, Miriam Hospital, Assistant Surgeon, Rhode Island Hospital, Providence, Rhode Island.*

THE MEDICAL HISTORY of Rhode Island is long and honorable. This account will be concerned largely with the education of doctors during the first two centuries, culminating in the establishment and eventual demise of the medical school at Brown University.

The first physician to join the colony was Doctor John Clarke who came to Portsmouth from Boston in 1638 and participated prominently in the founding of Newport in the following year. He had studied both medicine and theology at Leyden. In 1651 he returned to England with Roger Williams. During the succeeding twelve years he practiced medicine in London, devoting himself diligently in the meantime to the procurement of a new charter for Rhode Island. Following his return to Newport he officiated as pastor of the Baptist Church and practiced medicine until his death in 1676 in his sixty-eighth year.

The first medical degree awarded in Rhode Island and possibly anywhere in the colonies was conferred by the General Assembly, meeting in Newport on March 1, 1664, on Captain John Cranston. This was one of its first acts after receiving the Charter of 1663 previously referred to. John Cranston later became governor of the colony. It is well to review once again for the benefit of a new generation this quaint but important document:

> "Whereas the Court have taken notice of the great blessing of God on the good endevers of Captayne John Cranston of Newport, both in phissicke and chirurgery, to the great comfort of such as have had occation to improve his skill and practice, &c. The Court doe therefore unanimously enacte and declare that the said Captayne John Cranston is lycensed and commissioned to adminester phissicke, and practice chirurgery throughout this whole Collony, and is by this Court styled and recorded Doctor of phissick and chirrurgery, by the athority of this the Generall Assembly of this Collony."

About 1752 there arrived in Newport one Doctor William Hunter, a graduate of Edinburgh University, a pupil of the elder Monro and in his youth a surgeon's mate in the British Army. He was a cousin of the eminent brothers John and William Hunter of London. He is generally credited with having given the first systematic advertised public lectures on Anatomy and Surgery in the colonies. Doctor Benjamin Waterhouse wrote in 1824: "About the year 1756, Dr. William Hunter, . . . 'clarum et venerabile nomen' gave at Newport, R. I. the first Anatomical and Surgical Lectures ever delivered in the twelve colonies. They were delivered in the court-house two seasons in succession by cards of invitation, and to great satisfaction. His collection of instruments was much larger than any professor exhibits at this day. Dr. Hunter was a man of talents, well educated at Edinburgh and a gentleman of taste in fine arts. He practiced from the time of his public lecturing at R. I. till the British occupied it, and died a hospital surgeon in their service." He wrote further: "It should be born in mind, that when Dr. William Hunter taught publicly Anatomy and Surgery at Rhode-Island, the Medical School at Philadelphia was not in existence. . . . The Hon. William Hunter, now senator in Congress, is the son of the respectable physician just mentioned, and who has recently presented some valuable books belonging to his father's library, to that of the college of Rhode-Island at Providence [i.e. Brown University]." This collection of books at Brown University, first assembled and photographed by Doctor E. B. Krumbhaar for his scholarly account of Doctor Hunter, published in 1935, is now being maintained intact at the John Hay Library.

These lectures, which actually were delivered during the winters of 1754-55 and 1755-56, were advertised on several occasions in the BOSTON EVENING POST during January and February of 1755. He is credited also with being the first male accoucheur, i.e. obstetrician, in the colony. In 1761 he married the beautiful Deborah Malbone, daughter of the socially prominent Colonel Godfrey Malbone and aunt of Edward Greene Malbone, the talented miniaturist and artist.

He served as surgeon to Rhode Island troops during several campaigns against the French in the years 1755-1758, under both Abercrombie and Amherst, eventually being commissioned Surgeon General by the General Assembly. He proved in the end, however, to be an unreconstructed Tory and

succumbed to fever while attending troops in a British Army hospital in Newport during the occupation of that town in 1777, the forty-seventh year of his life.

Doctor John Halliburton who arrived in Newport in 1750, had been surgeon aboard a British frigate. He subsequently resigned his commission and married a daughter of the prosperous Brenton family. He died there in 1807. He is best known now for having been the first preceptor of Benjamin Waterhouse, who wrote of him and of Hunter: "We doubt whether Boston, New York or Philadelphia, ever had, at the same time, two practitioners of physic and surgery, better educated and more skillful than these two gentlemen."

Doctor Isaac Senter, also of this period in Newport, was a better patriot than the others and served in the field with Rhode Island troops as surgeon during the Revolution. He contributed several papers to European journals, and was according to Waterhouse, "quoted with approbation in Europe." Other scholarly and well-educated practitioners of the period were Doctors John Brett and Thomas Moffatt. The latter was a business associate of Gilbert Stuart's father in the snuff mill enterprise in South County.

The Waterhouse account of the Redwood Library is of considerable interest: "Sometime about the year 1754, Abraham Redwood, Esq. a judicious and opulent gentleman of the Society of Friends, founded the 'Redwood Library' and gave five hundred pounds sterling for books, to be purchased in London: which commission was judiously and faithfully executed. The medical part of them were excellent. They were amply sufficient to give the medical student competent information of all that was then known in the English language, on Anatomy, Surgery, Chemistry and Botany, together with the history of drugs, and of their various preparations and uses, with the history of the progress of Physic from Hippocrates to Boerhaave."

End of Golden Age

The golden age of Newport ended with the British occupation. Again we can do no better than quote the eloquent words of Waterhouse: "Suffice it to say, that before the Revolution, Newport was a large and flourishing town; that when it became an English garrison, the people of wealth and consequence quitted it, and the town of Providence rose on its ruins. Since then, that once beautiful spot resembles an old battered shield, long held up against the common enemy. The town of Providence has now become opulent, and got so far the start of Newport, as to be able always to keep it."

Before our change of scene we should pause briefly to consider the greatest of them all, Doctor Benjamin Waterhouse himself, whose major focus of activity was elsewhere, but who retained to the end a great devotion and admiration for his native state.

Benjamin Waterhouse was born in Newport in 1753. His mother was a niece of John Fothergill, the celebrated London physician. He attended Dean Berkeley's School, where Gilbert Stuart was a fellow student. At the age of sixteen he began the study of medicine under Halliburton. Setting out for Europe on the last ship to escape from Boston in 1775, he went first to Edinburgh where he studied under Cullen, Black and Monro. After a period in London during which he lived and studied with Fothergill, he went on finally to Leyden, seat of the great Boerhaave and achieved his M.D. degree there. He was appointed, in 1782, at the age of twenty-nine, the first Professor of the Theory and Practice of Physic at The Harvard Medical School. In 1782 he was elected to the Board of Fellows of the College of Rhode Island [Brown University]. In 1784, the college faculty was strengthened by the appointment of two professors "both of whom engaged to give Lectures in their respective Branches, without any Expence [*sic*] to the College while destitute of an Endowment." They were Joseph Brown and Waterhouse. The latter served without pay from 1784 to 1791. His duties at Brown did not seriously interfere with his obligations at Harvard as the daily routine in the former was carried out by tutors. He is best known for the introduction into America of cow-pox vaccination for small-pox, the material for which he obtained from Jenner himself.

He later wrote of Brown: "Its College or University, from very small beginnings, has attained a respectable standing, and is in a fair way of becoming eminent: and it may not be amiss to remark here, that the first lectures on Natural History, particularly in Mineralogy and Botany [i.e. his own], ever given in North America were delivered in the College of Providence, in the year 1784, or about three years earlier than they commenced at Cambridge."

Before proceeding I should like to indulge in a brief bibliographical digression. The materials

continued on next page

OBSERVATIONS.

MEDICAL LITERATURE OF RHODE-ISLAND,

WITH A SKETCH OF SOME OF HER MOST EMINENT MEN.

Communicated for the Boston Medical Intelligencer.

W.

Cambridge, July, 1824.

Fig. 1. Caption and ending of Waterhouse's important essay showing his identifying initial. (*Courtesy of The Rhode Island Medical Society Library*)

from Waterhouse quoted at length above come from his delightful essay titled: *Medical Literature of Rhode Island, with a Sketch of Some of Her Most Eminent Men.* This was published in the Boston Medical Intelligencer of August 3, 1824. It was signed merely "W., Cambridge, July 1824." I have found no reference to this original source dated after 1838, although much of the material has often been quoted and at least on one occasion incorrectly attributed.

Although the colony's cultural activities during the middle years of the eighteenth century were centered preponderantly in Newport, one foray into medical education in the town of Providence is worthy of note. Doctor David Vanderlight, a native of Holland and a graduate of Leyden, came to Providence about 1750, married Mary Brown, sister of the four potent Brown brothers and acquired a house on South Main Street. He ran an apothecary shop, and in addition gave the first known instruction hereabouts in anatomy. He received his students at his home. Since he died in 1755 it is possible that his course antedated that of Hunter in Newport. Among his effects were "1 case for an Anatomy, with bones." It has been stated by several authorities that he introduced into Rhode Island the technique used in Holland for separating spermaceti from its oil, a method used with great success by his brothers-in-law in the highly profitable manufacture of candles. Professor Hedges, however, in his careful studies of the Brown affairs has concluded that this claim is not well documented.

Interest in medical problems in that era of versatility was not confined to practitioners of medicine. Moses Brown, whose primary activity was in the commercial world, had a scientific bent not unlike that of his brother Joseph. Among his voluminous papers, now preserved in The Rhode Island Historical Society Library, are copious notes concerning his observations on cancer and yellow fever. His studies on yellow fever, which caused so much suffering and loss of life during the last decade of the eighteenth century, were directed both to its etiology and epidemiology. One of his lists of yellow fever victims contains the name of Doctor William Bowen, followed by the notation "Recovered."

Although there were in the colony and state throughout its early years a nucleus of well-educated physicians, a number of whom displayed M.D. degrees from European universities, it was, nevertheless, the usual custom for a physician to enter the profession through preceptorship for three or four years with some prominent practitioner. During such apprenticeship he was obliged to aid in the preparation of medicines, participate in the care of the sick and assist at minor operations. In return for these services he could expect instruction in the various branches of the medical art. The teacher gave the pupil, on leaving, a letter of recommendation which was his only credential. During the second decade of the nineteenth century, however, a feeling became prevalent that medicine should be treated as a science rather than as an outgrowth of intuition. It was as a result of this changing view that Brown University became interested in the establishment of a medical school during 1810 and 1811.

Medical Department at Brown

The charter of Rhode Island College which became Brown University in 1804, authorized it to "admit to and confer any and all the learned degrees which can or ought be given and conferred in any of the colleges or universities in America." Several times under this authority the degree of doctor of medicine had been granted to physicians already prominent in the profession. The first honorary M.D. degree conferred by the college was bestowed in 1804 upon Doctor Solomon Drowne, a graduate of the class of '73 and a bachelor of medicine from the medical department of the College of Philadelphia, 1781. Similar degrees were conferred in 1812 upon Pardon Bowen, Class of '75, and Levi Wheaton, Class of '82. The medical school itself was formally established in 1811, thus becoming the third oldest in New England following Harvard founded in 1782 and Dartmouth in 1798. The only other schools in existence at the time were those associated with William and Mary, King's College (Columbia), Queen's College (Rutgers) and the college at Philadelphia (later the University of Pennsylvania).

The organization of the new school in September of 1811, during the administration of President Asa Messer, was consummated by the designation of the first three members of the faculty: Solomon Drowne, Professor of Materia Medica and Botany; William Ingalls, Professor of Anatomy and Surgery; and William Corlis Bowen, Professor of Chemistry. A committee of the Corporation was then appointed to select a suitable candidate to give lectures on the Theory and Practice of Physic. For its day this was a fairly strong faculty.

Doctor Solomon Drowne

Doctor Solomon Drowne, who was born in Providence in 1753, studied locally with Doctor William Bowen and later received his degree in medicine in Philadelphia, as previously mentioned. Following extensive and highly regarded service as a surgeon in the War he returned to Providence to set up in practice. He was appointed to the Board of Fellows of Brown University in 1783. Feeling the need for further education, however, he pulled up stakes and sailed for Europe in 1784, where he

assiduously attended lectures and visited hospitals in both London and Paris. While in the latter city he became intimate with both Thomas Jefferson and Benjamin Franklin, who were in France at the time. Returning to America in 1788 he lived for a while in Ohio, Virginia and Pennsylvania before returning at long last to his native Rhode Island in 1801. He bought an estate in Foster where he built a spacious residence to live out the remainder of his days in a sylvan setting immersed in nature and the rural life of which he was so fond. On the grounds surrounding his lovely new home, to which he gave the name Mount Hygeia, he developed the first botanical garden in the state. His extensive collection acquired fame and attracted visitors from great distances. The homestead still stands, though in a distressing state of deterioration. Its original charm, nevertheless, can still be felt. Title to the property, still residing with the Drowne heirs, is bogged down in almost insurmountable legal complexities, Doctor Drowne having left no will. Adequate funds to restore and maintain the property have not been available. Many of his papers, lectures, notes and letters, as well as the bulk of his personal library, are now in the possession of the John Hay Library having been donated by the family a number of years ago. More recently the remnants of his personal library were salvaged from the attic of the old house and were added to this collection. Doctor Drowne lies buried nearby in the family plot, his grave marked by an aged headstone which recounts in terse but dignified phrases the above biographical data.

Doctor Drowne was a very popular lecturer. Under his direction the students began on the college grounds a botanical garden, which was a source of considerable pride to him and which existed according to his own word at least until 1824. He was, it appears, better fitted for a life of contemplation and study rather than for the routine of medical practice. It has been said that if, on the way to visit a patient, he recognized an interesting botanical specimen, he would stop and perhaps spend the whole day in the fields or woods. A vice-president of the Rhode Island Medical Society, he was sent as a delegate to the convention that formed the National Pharmacopeia in 1819. In this connection the following notation in the minutes of the Society for September 5, 1820, are of interest: "Voted. That the collection of Fines and Taxes due from Solomon Drowne be suspended until his settlement with the Society for attendance at Boston as a member of the committee for forming a National Pharmacopoea [*sic*]." Three years elapsed before he finally "received $25 from the Treasurer of the Society on acct of his attendance." Following the closing of the school, he lived on another seven years, passing on in 1834, in his eighty-first year.

Doctor William Ingalls

Doctor Ingalls, although somewhat less colorful, was nevertheless a prepossessing figure. A graduate of Harvard in the Class of 1790, he received his bachelor of medicine in 1794 and his M.D. in 1801, both at his Alma Mater. His whole professional life was spent in Boston where he gained considerable prominence because of his skill as a surgeon and because of his early opposition to the practice of bleeding. He kept a private room for the study of anatomy as well as a museum of anatomical preparations in his home on School Street. In addition, he maintained an anatomical lecture room on Market Street, where he regularly met with his students, averaging as many as twenty-five to thirty. After his appointment at Brown in 1811, he lectured in Providence regularly until 1815. At that time he offered his resignation, feeling that the poor financial reward did not warrant his trips to Providence. For some time students were permitted to attend his lectures in Boston and were permitted to use the credits toward their degree. To help fill the gap, Doctor John Mathewson Eddy was appointed adjunct professor, but he died prematurely barely two years later. He was a founder of the Rhode Island Medical Society and was considered to be a man of considerable promise. It was written of him that he was "cut down in the midst of [his] usefulness, which should serve to remind us of the uncertain tenure of our own lives."

Doctor William Corliss Bowen

Doctor Bowen, the final member of the original triumvirate, was an only son of the eminent Doctor William Bowen. He was born in the family home at the foot of College Street in 1785. After matriculating at Rhode Island College, he transferred to Union College where he graduated in 1803. After commencing the study of medicine with his uncle, Doctor Pardon Bowen, he went on to Edinburgh, receiving his M.D. there in 1809 (or 1807). Following this, he studied also in Paris and in London where he was a private pupil of the great Sir Astley Cooper. He was a young man of brilliant attainments and yet at the same time had a kindness of manner which endeared him to his patients. As a diversion from his medical preoccupations he became engaged in extensive experiments with bleaching solutions. This activity laid the foundation for the bleaching industry which thrived for many years during the era of textile prosperity in Rhode Island. He died in 1815, his thirtieth year, of tuberculosis which was thought to have been aggravated by the prolonged exposure to chlorine vapor. "In the death of Dr. William C. Bowen," wrote Doctor Usher Parsons, "Rhode Island lost its brightest

continued on next page

ornament of the medical profession."

About this time there appeared in the form of a pamphlet dated August 18, 1815, "A Letter to the Corporation of Brown University, suggesting certain Improvements in its Academical System," signed merely "Alumnus Brunensis." As one who had "not been at all times wholly unconnected with the Institution, . . . and who still recollects with affection his alma mater," he begged "respectfully to offer a few reflections on its present situation, and on the possibility of its improvement."

"A Medical School complete in all its parts," he asserted, "and conducted with ability and zeal, is a most important portion of a University. Ours is incomplete. The departments of Chemistry, and of the Theory and Practice of Medicine, remain to be filled. And they must be filled. If it is designed that the school shall ever have extensive reputation, there is no excuse for the deficiency. Two able Professors fill the other departments. But will medical students extensively resort to a school 'but half made up,' when complete establishments are inviting their patronage on every side? It cannot be. . . . Unless a remedy be soon applied, it will become the established reputation of the School that it is essentially incomplete: and after such a reputation shall have become established, it will require many years of complete operation, should that event ever happen, to remove the injurious impression. . . . Not a moment ought to be lost in completing the establishment, especially since not a single serious obstacle appears to oppose its completion. There is certainly no possible difficulty in obtaining an able person for the department of the Theory and Practice of Medicine. And for that of Chemistry there is a gentleman within a few miles of the institution eminently fitted, could be induced to engage for the good of the College. . . .

"To the department of Anatomy and Surgery also ought to be added that of Physiology. This subject is very important to medical students, while to general students it is by far the most interesting of all medical branches. . . .

"The Lectures of the Professors should be aided by regular classical recitation. . . . Taking anatomy as the example, let the method be this. Let a concise text-book be adopted, comprising the principles of Anatomy: and let this be in the hands of each attendant. Let this text-book, as nearly as possible, guide the Lecturer in arranging his plan of Lectures. . . ."

These proposals were certainly pertinent and valid, although as pointed out by Professor Bronson, the need for laboratories and clinics was not sufficiently evident for them even to have been mentioned.

On another sore point, the writer continued as follows: "Another improvement in this department is very essential. On the present plan, the professors depend for compensation entirely on the fees of attendance. This gives them a most precarious standing. Repeatedly has it been the lot of a professor, as the season for his lectures approached, to visit the college, inquire how many attendants would be had, be informed that for this and that reason they would be very few, and return to his residence, lamenting that he must wait another year, because an unfortunate arrangement has made the discharge of his duties dependent on the accidental finances and feelings of fifty or sixty youth. This state of things is too humiliating. It has already occasioned the loss of one distinguished professor [Dr. Ingalls]. Let the evil be remedied. Let therefore a certain sum be annually paid from the treasury to each of the professors. . . ."

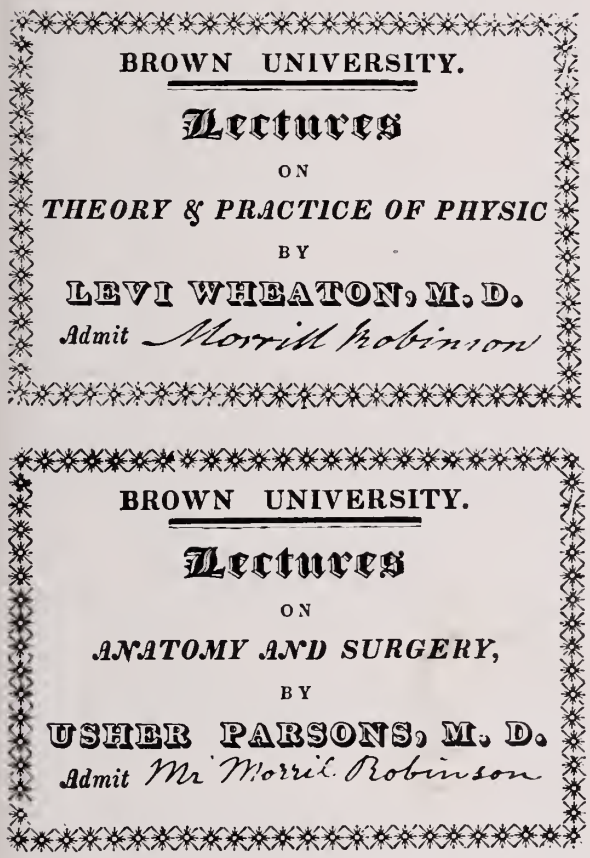
Whether or not the proposals vigorously outlined in this broadside were heeded, the fact is that shortly thereafter Doctor Levi Wheaton was appointed professor of the Theory and Practice of Physic and Doctor John M. Eddy was appointed to his brief tenure as adjunct professor of Anatomy and Surgery. The chair of chemistry, which had been vacated by the enforced retirement of Doctor Bowen in 1813, was not filled until 1817. Doctor John Mackie of Providence had been offered the post in 1815, but had declined. The new professor of chemistry was John DeWolf of Bristol.

Doctor Levi Wheaton

Doctor Wheaton, born in Providence in 1761, attended Rhode Island College from which he received his A.B. degree in 1782. His medical experience began as a volunteer in the Military Hospital in Providence in 1778. He studied medicine during the succeeding two years with Doctor Joshua Babcock of Westerly and Doctor William Bowen of Providence. After completing his medical studies he served as surgeon on board a privateer, from which he was taken prisoner by the British and brought to New York. He took charge for several months of the prison hospital ship *Falmouth*. At the end of the war he moved to Hudson, New York, which had been founded by settlers from Providence, and practiced there for ten years. He later removed to New York City where he practiced for about two years, returning to his native town about the turn of the century. He was elected a trustee of Brown University in 1789, serving in that capacity for the remainder of his life, and was awarded an M.D. by his alma mater in 1812.

Doctor Wheaton was described by a contemporary as a "thoroughly read and sound practical physician . . . entitled to preeminence: but . . . still more so . . . a man of erudition and general scholarship." He was solicitous for his patients and conscientious in their care. His lectures at the medical school were considered to be "very creditable to his talents." He was the author of medical papers on

yellow fever, on the use of calomel and on Asiatic cholera, and for a number of years contributed to the Boston Medical and Surgical Journal over the signature, "Senex." Unlike his colleague, Doctor Ingalls, he was an enthusiastic exponent of phlebotomy in the treatment of disease. He served for many years as physician to the Marine Hospital at the Port of Providence, there being some implication that he utilized this clinical material in his teaching. After a long and fruitful life, he departed these realms in 1852 in his ninety-second year.


BROWN UNIVERSITY.

Lectures

ON

THEORY & PRACTICE OF PHYSIC

BY

LEVI WHEATON, M. D.

Admit Morrill Robinson

BROWN UNIVERSITY.

Lectures

ON

ANATOMY AND SURGERY,

BY

USHER PARSONS, M. D.

Admit Mr Morril Robinson

Fig. 2. Examples of tickets admitting students to Medical School lectures. (*Courtesy of The John Hay Library, Brown University*)

Doctor John DeWolf, Jr.

John DeWolf, Jr., great-grandfather of Doctor Halsey DeWolf, was born in Bristol, Rhode Island, in 1786. Although he matriculated at Brown, he did not graduate. He obtained his chemical education from the celebrated Doctor Robert Hare of Philadelphia, who later became professor of chemistry at the University of Pennsylvania. Considered to be a brilliant lecturer and experimenter, DeWolf served as professor of chemistry at the University for twenty years. A graduate of the class of 1826 who had attended the lectures wrote: "The chemical apparatus belonging to the college was very limited and imperfect,—hardly worthy of the name. It was understood that he used his own apparatus, which he brought with him, whenever he commenced a course of lectures and experiments. He had a very happy faculty of communicating the truths of the science to the youthful mind." He was sought after as a public speaker in the community because of his "finished rhetoric" and "sparkling wit" and he attained some renown as a poet. Following his departure from Brown he taught chemistry at the medical colleges at Woodstock and Castleton, Vermont, and later at the medical school at St. Louis. He subsequently retired to his native town where he passed on in 1862 at the age of 76.

Doctor Usher Parsons

Although the last remaining accession to the faculty of the school, filling the vacancy left by Doctor Eddy's untimely death, did not occur until 1822, we shall consider it before proceeding to other matters. The new incumbent of the chair of Anatomy and Surgery, Doctor Usher Parsons, was born in Alfred, Maine, in 1788. His medical studies, begun in 1807 in the office of Doctor Abiel Hall in his home town, were pursued at Fryeburg, Maine, under the tutelage of Doctor Alexander Ramsay, a skillful anatomist and stimulating lecturer. In 1811 he moved on to Boston "determined to obtain the degree of A.M. and M.D., and to become a teacher of anatomy." He entered the office of the eminent surgeon Doctor John Warren, a professor in the Harvard Medical School and brother of General Joseph Warren, himself a physician, who fell at Bunker Hill. Following completion of these studies he was examined by the censors of the Massachusetts Medical Society and was approved and licensed "a Practitioner in Medicine," on February 7, 1812. After several unsuccessful attempts to find a suitable location in which to practice and with the imminent prospect of war, he sought a naval commission. This was granted in July 1812. He saw distinguished service with Commodore Oliver Hazard Perry at the Battle of Lake Erie where he was, in fact, the only surgeon present due to the illness of two other medical officers assigned to that action. He served later in the Mediterranean Theater as well. In the course of time he rose in rank from surgeon's mate to surgeon. As a result of his highly successful treatment of the wounded at Lake Erie a citation was sent by Perry to the Secretary of the Navy and in addition he became Perry's close personal friend. Out of nearly one hundred wounded in the battle, he lost only three, a respectable figure even for this day. This was the beginning of his reputation as a surgeon.

While in the Mediterranean service he found time to visit medical centers at Naples, Palermo, Rome and Florence. After returning to New Eng-

continued on next page

land in 1817 he attended lectures at the Harvard Medical School, receiving there the degree of M.D. in March, 1818. In that same year he published (in the New England Journal of Medicine and Surgery) his famous *Surgical account of the Naval Battle on Lake Erie*. During a subsequent naval cruise in Europe he sought for and was granted a leave of absence on account of his health. This gave him an opportunity to visit clinics in Italy, London and Paris. He took copious notes and bought many medical books and instruments.

Following his return to the States in 1820 he was chosen Professor of Anatomy and Surgery at Dartmouth, fulfilling at last his long-standing ambition. He served there, however, only one year. At this time he wrote and published *The Sailor's Physician*, which was to go eventually through five editions. He made an extended trip to the medical schools in New York, Philadelphia and Baltimore, attending lectures at all of them.

His long residence in Providence began in April, 1822, when he entered practice for a while as partner to Doctor Levi Wheaton. In the same year he married Mary Jackson Holmes, elder sister of the later famed Oliver Wendell Holmes. Oliver was thirteen at the time. Mary Parsons died in 1825, after only three years of marriage, leaving one son. She was, it appears, a charming and gifted woman. Correspondence between Oliver and Doctor Parsons covered a period of many years, during which Parsons served as confidant and advisor to Holmes both during his medical studies at Harvard and abroad. Many references to Parsons may be found in Holmes's published letters. A communication from Doctor Parsons to the curator of the Hunterian Museum in London was most helpful in getting Holmes an entree to that renowned institution. On one occasion while in Paris young Holmes bought two skeletons, one for himself, and a showy one for his brother-in-law, which he sent to him along with some "new-fangled instruments," some botanical plates and some medical texts.

Since the death of Doctor Eddy in 1817, the fortunes of the Medical School appear to have been at a low ebb. With the appointment of Doctor Parsons to the position of Adjunct Professor of Anatomy and Surgery in 1822, the school was "reorganized." Wrote his son, Doctor Charles W. Parsons: "A plan of giving lectures in Brown University, which had failed in 1817, was resumed in 1822." He wrote further: "The opening of courses by Doctor Parsons gave new life to the institution. He made arrangements, through channels over which a veil of secrecy had to be thrown, for a supply of anatomical material. He was the owner of valuable and novel representations of human structure in wax models made in Italy. He had learned from Doctor Ramsay the methods of displaying and preserving the perishable organs." In 1831 he published a handbook titled *Directions for Making Anatomical Preparations*, which outlined the then current methods.

In 1823, he was promoted to professor and in the same year he resigned his commission in the navy. Although his academic career at Brown ended with the closing of the school barely four years later, he had a long and distinguished career in medicine in Providence. A bibliography of his writings published by his son comprised fifty-eight items, containing many historical as well as medical essays. On four occasions he won the Boylston prize for dissertations on medical subjects and in addition the Fiske Fund prize of the Rhode Island Medical Society. He prepared in 1826 a series of lectures on anatomy and physiology for the upper classmen at Brown and introduced it with an eloquent and forward looking exposition on "The Importance of the Sciences of Anatomy and Physiology as a Branch of General Education." A study titled "On the Administration of Medicines by the Veins; Being a Brief Inquiry into its Safety and Utility" appeared in 1828. This interesting investigation, employing animals (sheep) as subjects and a variety of pharmacotherapeutic materials (including arsenic), although producing discouraging results, nevertheless antedated the work of Ehrlich by almost a hundred years. He affirmed rather dogmatically "that the introduction of medicine by the veins can never be practiced with utility or safety, even in the few cases where, from obstructed deglutition, or other causes, they are inadmissible by the stomach." He was responsible also for a rather involved study published in 1830 "On the Comparative Influence of Vegetable and Animal Decomposition as a Cause of Fever." He concluded that either could be an effective cause. In a rather intriguing essay "On the Use of Alcohol in the Disease Produced by the Bite of the Rattlesnake," he opined that "the stimulus no doubt counteracted the poison." Much more highly perceptive was his "Lecture on the Connection and Reciprocal Influence Between the Brain and Stomach" which appeared in 1840. He was undoubtedly influenced by the monumental work of William Beaumont appearing between 1825 and 1833 to which he made reference. Wrote Parsons: "The nervous and dyspeptic complaints incident to adult persons, whose brain or instrument of the mind is constantly overexcited by emulation, ambition, anxiety, tribulation, and a thousand other causes, are constantly multiplying in frequency and intensity, with the increase of population, and with the march of intellect and refinement. The fury of politics, the jealousies, envyings and rivalries of professions, the struggles for office, the contentions of trade, the excitements of speculation, and the

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SOCIAL SECURITY AND THE MEDICAL PROFESSION

THE POSITION of the American Medical Association, speaking for the physicians of America, has been set forth on several occasions in recent years in the debates on the inclusion of doctors under the federal social security system. In June, 1949, the House of Delegates adopted a resolution strongly opposing compulsory coverage of physicians. In December, 1953, another resolution was adopted reaffirming the Association's support and endorsement of the *voluntary* pension program provided in the then Jenkins-Keogh bills, and its strong opposition to the extension of compulsory coverages under the Social Security Act.

In February, 1954, the Board of Trustees of the A.M.A. again reviewed this question and reaffirmed the Association's position of opposition to compulsory coverage, but the Board did determine that no objection would be raised to the extension of the Old Age and Survivors Insurance provisions of Title II so as to permit *voluntary* coverage of physicians.

There have been presented to Congressional committees many sound and valid reasons why physicians do not wish compulsory social security, basically because old age benefits under the program do not fit the economic pattern of the life of the self-employed physician. The A.M.A. has, together with many other organizations and individuals, asked for Congressional support of bills before the Congress that would provide a long-range plan for encouragement through tax deferments for self-employed people to set aside limited amounts from their earned income into restricted retirement annuity or pension trust programs from which they could draw benefits on attaining age 65.

The Rhode Island Medical Society, acting through its Council and House of Delegates whose daily contact with the membership of the Society guarantees a sound reflection of the views of the majority, has concurred with the action taken at the national level.

In some parts of the country, notably New York City, physicians have been vociferous in their statements that all physicians should be covered under the social security system on a compulsory basis. It is not known how these same physicians would vote if the proposal were to be subsequently advanced that for an additional tax the federal system add compulsory medical care to its program, and all doctors would then be indirectly government employees.

This spring our House of Delegates authorized the mailing of a ballot to each member with supple-

continued on next page

mentary information giving factual data on a reappraisal of social security. Every effort was made to inform the doctor that he might make his decision clearly and express his views without being influenced by any group. Ballot did not even require a signature, if the physician preferred not to make it.

The summary of the membership poll recently submitted to each of the district society secretaries indicated an overwhelming refusal by Rhode Island Medical Society members of compulsory social security coverage. Only 7.5% of those voting favored compulsory coverage, whereas 33% opposed any inclusion whatever, and less than one-third who favored voluntary coverage would go along with compulsory provisions if the government denied voluntary inclusion.

This clear-cut expression by the individual members of the Society on this important question indicates that our district societies have chosen as elected representatives on our policy making bodies physicians who have honestly reflected the opinion of their constituent association's membership in establishing state and thereby national policies affecting medicine.

Of all the local organizations with which we are familiar, we think we can state without fear of repudiation that ours operates as an outstanding democratic body that seeks what is best for the majority, whether that majority is the public in matters of public and general welfare, or a majority of our own membership when the issue is one that concerns us primarily and directly.

Our Council, composed of the five most recent living former presidents of the Society, the current officers, and a Councillor elected by each of the seven district societies, serves as a board of trustees to carry on the work of the Society throughout the year. The Council in turn is subject to the final decision of the House of Delegates, meeting regularly three times annually, and composed of one delegate for each twenty Fellows of the Society, said delegates to be elected by the component district societies on the basis of their active membership total.

COMMENDABLE COMMUNITY ACTION

We have read a good deal in recent years of the action of communities in some of our large rural states of the west and midwest in solving their physician needs by providing the facilities for a doctor to work in the area under the most favorable conditions. Here in the nation's smallest state, criss-crossed by four-lane highways and with no citizens more than twenty miles from a modern hospital, and certainly not that distance from a physician, the problem has been a minor one.

However, the development of suburban residential areas—and in our state suburban soon becomes semi-rural once beyond the perimiter of metropolitan Greater Providence, Pawtucket, Central Falls, Cranston and East Providence—has focused attention on the importance of a physician in residence in some of our formerly small communities. Charlestown, Richmond and Hopkinton tackled the problem of securing a physician a year or two ago as a tri-community action. Scituate has attracted a physician within the past year, and now Glocester, thirtieth ranking town by population status in the 1950 census, and claiming fifty-six square miles of jurisdiction, has shown how a community can secure a physician to meet its needs.

By forming a "doctor for Glocester committee" the residents of the town acquired support from residents to endorse bank notes guaranteeing a twenty thousand dollar loan for the construction of a combination residence and office building to house a physician and his family. Land was donated by the chairman of the committee, and in a relatively short time construction is scheduled to start. The community gesture was soon noted, and at this writing a physician and his wife, who is also a physician, both currently Providence residents, will establish their practice in the town taken from Providence 225 years ago and named from Frederick Lewis Duke of Glocester, son of King George II.

It is this type of community action that made our communities with their town meetings famous and independently progressive in the early years of New England's growth. It is the same type of community action that can solve many of the seemingly complex situations in this twentieth century.

INTERIM MEETING—OCTOBER 26

With the American Medical Association honoring New England for the first time in more than thirty years by holding one of its major scientific sessions in the area—the Interim Clinical Session is at Boston starting November 29—many local medical organizations are curtailing on their own meeting programs for the fall season.

We are pleased that the Committee on Scientific Sessions of our Society has voted to go ahead with the annual Interim Meeting, and we are doubly pleased upon reading the outstanding program that has been arranged, copy of which is published elsewhere in this issue of the JOURNAL.

A symposium on diseases of the colon by such an array of outstanding panelists as Claude Welch, Franz Ingelfinger, Richard Schatzki, all of Boston, and John Garlock of New York, promises one of the finest afternoons of clinical medicine that has been offered our membership in years. The decision to hold the meeting in Providence, and the scientific session at the Medical Library, should appeal

to everyone.

We have checked Wednesday, October 26 on our calendar as a *must* meeting to attend. We advise every member to do likewise.

X-RAY BENEFITS ADDED

When the Blue Cross hospitalization program gained momentum twenty years ago, plans in some areas included such medical benefits as anesthesia and radiology. With the start of the Rhode Island Plan all parties concerned agreed that these medical benefits should not be included as hospital services, but that if and when the physicians of Rhode Island established a Blue Shield type of program the inclusion be left to that plan.

The start of Physicians Service in 1949 saw the realization of part of this decision made a decade previously, as anesthesia was included along with surgery and medical visits in the hospitals.

Now, with the Physicians Service program widely accepted, and with a desire to extend benefits in accordance with public requests, X rays and electrocardiograms have been added to the schedule of indemnities for a small additional premium. This step should certainly win popular approval in view of the wide use of radiological services in medical practice today.

Physicians Service has proceeded carefully in expanding its program in the best interests of the people whom it seeks to serve. A year ago the late Doctor Joseph O'Connell, then president of the Corporation, pointed out that the developments and expansion of benefits within the premium charge left little margin for emergencies, and none for extension of the program. Now, after six years of successful service, Physicians Service makes its first increase in the subscriber charges, and in so doing adds the important radiological coverage, both in and out of the hospital.

N. E. HOSPITAL INTERNATIONAL PROGRAM

While cameras clicked in Geneva, Switzerland, recording an epochal meeting between the foremost leaders of the world for securing world peace, news reached our desk of another step being taken to further the cause of international amity through medicine. This step forward has not been heralded with as much publicity, true, but it interests us because it is initiated in Boston and since it is a medical "first," we feel it worthy of honorable mention.

The New England Hospital of Boston, Massachusetts has launched an international educational program for women physicians. Its aim is to provide advanced medical training and opportunities for women physicians of foreign countries who wish to avail themselves of it to render better medical services to their own countrymen. The bulletin issued by the New England Hospital brings out the point that: "In this country only 6% of our medical students are women. In many other countries today the number ranges from 10% to 50%. . . . However while medical education is available to them in schools, there are not sufficient hospitals nor qualified staff and teachers to provide the advanced education in residencies and internships that is necessary to round out their experience and knowledge." The primary purpose of the New England Hospital Trustees and Staff in preparing a well-rounded all-comprehensive educational program for qualified women physicians from other countries is in "extending the frontiers of good medical care, throughout the world."

The New England Hospital, founded in 1862, pioneered in seeking greater opportunities for women in medicine at a time when their activities in this field were frowned upon. It has continued its chartered purposes and has created high levels of medical education and opportunity for women these past 93 years.

It is particularly fitting then it seems to us, that at this particular time—when there is so much need for greater international understanding, the New England Hospital should be the first to offer its advantages to medical women from foreign countries in a gesture of friendliness and thus spread the knowledge of American medicine to the confines of the earth.

We feel that the action of the New England Hospital in broadening opportunities for training women doctors is an important one. So, we asked Dr. Vidal to review the matter and are very pleased to put in her remarks and also her accompanying letter to the editor which we feel has some very pertinent observations. —THE EDITOR

* * *

Editor-in-Chief
Rhode Island Medical Journal

Dear Editor:

I am not at all certain that I have treated this international program with sufficient enthusiasm. However I could not refuse your kind request to at least surrender mine humble opinion. I shall not be the least offended if you cannot accept it.

I invariably squirm when I anticipate or begin to hear pointless discussions on: men *vs.* women in the Medical Profession, and have never felt like carrying the torch unduly for my sex in the field. I believe it to be an individual and rather sacred matter, that of a man or woman's dedication to an ideal where percentage and per capita ratios between one sex and the other are hardly the measures of ability or success, nor the justification thereof.

Sincerely,
JEANNETTE E. VIDAL, M.D.

THE ADOLESCENT'S PERSONALITY: IMPLICATIONS FOR TREATMENT

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sons for return appointments than does a psychiatric one. Patients who are at first reluctant to return often lose their initial resistence after the visits which additional medical or laboratory procedures require; or may be willing to return in order that we may discuss with them the results of the routine laboratory work, or a sore knee, or that we may complete the physical examination. These reasons get them back to us in instances when they would balk at a return visit "just to talk."

Sam's mother was deeply worried because of his "terrible feelings of depression, his marked inferiority complex, and his inability to get along well with his companions." This sixteen-year-old boy's father and mother were divorced; the latter had custody of the children. Sam's elder brother had left college because of a severe emotional disturbance and his younger brother was said to have emotional difficulties.

At his first visit our patient was very suspicious, antagonistic, and extremely defensive. He said he had been told to stay out of sports and to wear a knee bandage. He talked about a variety of symptoms and expressed resentment at his restrictions from athletics. It was clear that he was confused and depressed and that he had unfortunate personality traits, but he was reluctant to return for any further visits. Sam denied, although he had been talking a great deal about his various difficulties, that he had any problems, and he refused to discuss them. He said he would not see a psychiatrist under any circumstances.

In the hope that on further acquaintance Sam's defensiveness would lessen, he was told that his knee condition was of sufficient importance to warrant attention and observation, and that it could be helped. He was willing to come back on this basis. On the subsequent four or five visits we ostensibly were concerned only with his mild Osgood-Schlatter's Disease, and cautiously helped him to gain some insight into his emotional difficulties. After a few visits Sam accepted a referral to a psychiatrist and is currently receiving treatment.

In a general practice clinic such as ours various physical aspects of illness as well as laboratory examinations can be used to have a patient return for successive visits in the hope that as a relationship to the physician develops it will later be possible to refer the patient to a psychiatrist. Some who need an expert's help but who, despite our efforts, refuse to see a psychiatrist, are willing to come in to see a "medical doctor." If this physician has the advantage of a psychiatrist's supervision, as he does in our Unit, he may be able to give support and treatment which is needed. While none would consider such a recourse ideal, it is obvious that a physician trained in this way should be at least much better for this sort of patient than no treatment at all.

We all need to know more about adolescents. They are, after all, the adults of tomorrow, the inheritors of our civilization. Those who are now handicapped, or whose personalities and future effectiveness and happiness are threatened, have still the hope of change for the better. Later, and soon, that malleability, that capacity for change will be largely lost. Adolescence is the latest of the age periods in which we can expect success from other than the most expert and the most prolonged efforts to strengthen personalities or to build emotional or physical health. But not only those who brought troubles up from their early childhood and into adolescence now need and would benefit from understanding help. So, too, would those who waver and threaten to succumb to the conflicts, confusion, and stresses which the normal changes and events of adolescence put upon them. Clearly the better we understand these changes, the better we understand the nature and the kind of problems which beset these young people, the more effectively we can help them.

Some adults intuitively say and do just the thing that tips the balance in a troubled adolescent's favor, while others though better informed may fail to be of assistance. This, however, does not mean that a greater knowledge of adolescents is of little value. It does mean that knowledge *without feeling* may be useless. These young people are not yet independent—they are only striving to be; how you *feel* toward them, can be a greater factor than what you *know* about them. There is all the difference in the world between understanding *adolescence* and being interested in an adolescent. But an adult who is really interested in young people, and who feels genuinely sympathetic toward them, will be able to do more for them as he acquires a greater knowledge of their traits and needs and problems.

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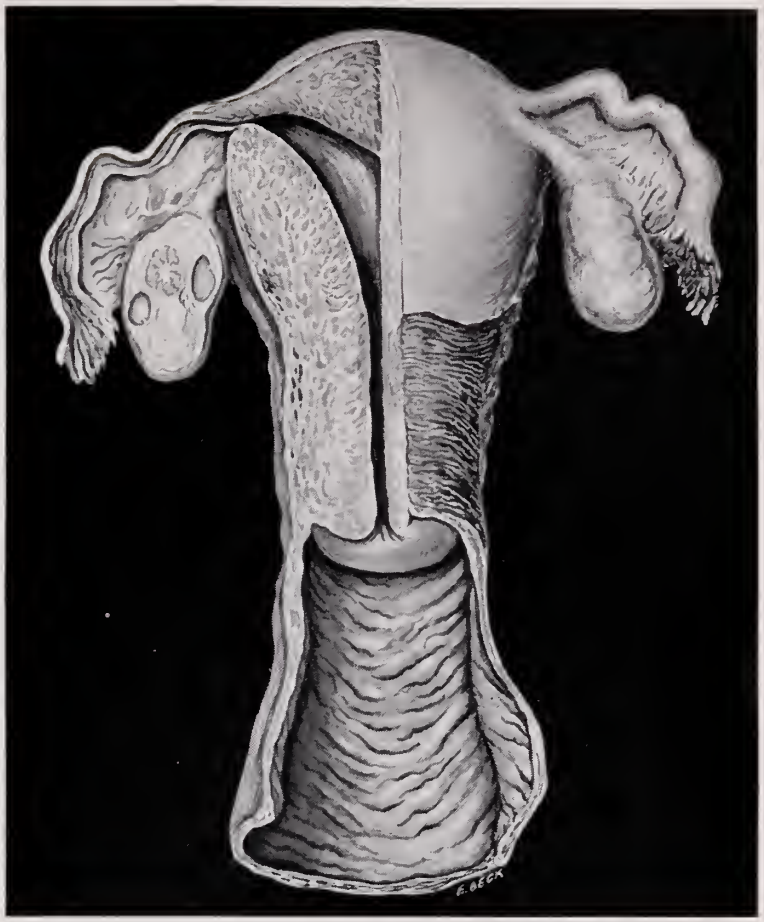
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*Sturnick, M. I., and Gargill, S. L.: New England J. Med. *247*:829 (Nov. 27) 1952.

SEARLE

INTERIM MEETING PROGRAM

of the

RHODE ISLAND MEDICAL SOCIETY

WEDNESDAY, OCTOBER 26, 1955

At the Rhode Island Medical Society Library

FRANK B. CUTTS, M.D., President, *Presiding*

3:00 P.M. ***Symposium on Diseases of the Colon***

"DIAGNOSIS OF DIARRHEAL STATES"

FRANZ J. INGELFINGER, M.D., *of Boston, Massachusetts*

Associate Professor of Medicine, Boston University School of Medicine

"MANAGEMENT OF DIVERTICULITIS"

CLAUDE E. WELCH, M.D., of Boston, Massachusetts

Visiting Surgeon, Massachusetts General Hospital; Clinical Associate in Surgery, Harvard Medical School

"SURGICAL TREATMENT OF ULCERATIVE COLITIS"

JOHN H. GARLOCK, M.D., of New York, N.Y.

Senior Surgeon, Mt. Sinai Hospital, New York City; Clinical Professor of Surgery, Columbia Medical School

"DIFFICULTIES AND PITFALLS IN THE ROENTGENOLOGICAL EXAMINATION OF THE COLON"

RICHARD SCHATZKI, M.D., of Boston, Massachusetts

Assistant Visiting Radiologist, Massachusetts General Hospital; Chief Roentgenologist, Mt. Auburn Hospital, Cambridge; Instructor, Harvard Medical School

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General Discussion

6:00-7:00 P.M. RECEPTION, Narragansett Hotel, Providence

7:00 P.M. DINNER for Members of the Society, Auxiliary and Guests

Speaker: DR. HUGH SHIELDS, of Ridgefield, Connecticut. One of America's outstanding humorists and the nation's foremost interpreter of James Whitcomb Riley.

Subject: "SENSE AND NONSENSE"

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MEDICAL DEFENSE AND GRIEVANCE*

CHARLES J. ASHWORTH, M.D.

The Author, *Charles J. Ashworth, M.D., Past President, Rhode Island Medical Society; President, Rhode Island Medical Society Physicians Service.*

THIS COMMITTEE of the Rhode Island Medical Society dates its origin back more than twenty-five years, one of the oldest among state medical societies. Its function recently has been broadened because of the widespread publicity given through many nationally circulated magazines to the laity, some of whom have published material, embellished with eye-catching headlines, to project the physician as an object of attack through county and state medical society grievance committees. This is pointed out for the purpose of emphasizing the twofold function of such committees as a basic objective.

One is to provide a means whereby any patient may have recourse to complain about the conduct of a case in the hands of an individual doctor. The other is to give the physician when complained against, sued, or threatened with suit, an opportunity to present and substantiate his part in the matter under dispute. This latter was the original purpose of our committee, but recent years have developed newer aspects of these differences between doctors and patients. We now hear both sides of some controversies before any legal action is started. In many instances, these cases are resolved satisfactorily by the committee, and most often on the basis of misunderstanding between the parties involved.

A difficult and not too infrequent situation arises when there is criticism by one doctor of another's handling of a case. So slight a gesture as raising one's eyebrows might be the basis for creating doubt in the mind of a patient about the treatment received by another physician. On the other extreme is the height of indiscretion for any doctor to remark: "Well, that's a poor result"; or the in between innuendo, "I wish I had seen you earlier." Without doubt, these remarks are not made with malicious intent, but by their very carelessness, plant a seed of dissatisfaction in the mind of the patient that often germinates subsequent action leading to suit.

*Presented at the Annual Meeting of the Rhode Island Association of Medical Record Librarians, at Providence, Rhode Island, May 4, 1955.

A poor result, something less than was anticipated or desired by the patient, or the development of a complication never intended and much less designed by the doctor, is often the problem. In cases of this kind the question of carelessness on the doctor's part arises, or, the question as to whether he exercised the usual degree of skill recognized in the particular community.

Other causes for inviting malpractice action referred to grievance committees include:

Lack of proper consent (especially minors)
Poor or carelessly kept records
Specific instructions
Lack of coverage when absent
Abandonment of a patient
Responsibility for assistants
Telephoned prescriptions
Collection dangers and over charging
Thinking out loud
Guaranteeing success
Bragging about or even admitting insurance coverage

While these causes may seem trivial, it becomes quite evident that many suits have resulted from the doctor's invitation through indiscretion in word or act, and carelessness.

These cases reach the committee through letters from the complainant, an attorney or insurance carrier, or the doctor. All pertinent information is obtained, and all parties involved are offered an opportunity to appear before the committee. The complaining person when so appearing has many times been made aware of some misunderstanding and the situation adjusted or the advice to adjust it with the doctor in question often followed.

When the doctor is or is about to be a defendant in a malpractice action, every conceivable fragment of evidence is secured and considered, the doctor invited with or without an attorney, to state his case, and the committee then assesses the facts to determine:

1. Is there negligence on his part?
2. Is the case defensible?
3. Has it only nuisance value?

One can readily understand that when the medical implications have been deliberated by the committee, legal opinion and other assistance is inevitably necessary in arriving at a decision or recommendation. These deliberations are made

concluded on page 512

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MEDICAL DEFENSE AND GRIEVANCE

concluded from page 510

during the doctor's absence from the room, but the results are communicated to him immediately, by word of mouth. Further action then depends upon subsequent developments.

The widespread existence and ever increasing number of grievance committees, called by other names in different localities, as professional conduct committee, patient-physician relationship boards, and others, materially extends the role of the practicing physician today. Being well schooled as well as adequately trained, he embraces not only those responsibilities inherited from previous generations of his profession, but also acquired obligations inseparable from the ever expanding and progressing development in the art and practice of medicine. From the very meager literature presently available, it is quite obvious that among the many possible reasons for complaints presented to these committees, two things every doctor has to be most careful about are: First, rendering each patient the very best care not only of which he is capable, but consistent with the standard of the community in which he practices; second, making charges neither inconsistent with the service and skill rendered, nor in excess of prevailing fees for the same or similar services; and, most important, not charging beyond the financial ability of the patient to pay.

Despite the general observance of these requisites, a doctor often finds himself charged with negligence when factors far beyond his control produce an undesired result. Medicine is not an exact science, and its practice therefore calls for the assumption of certain calculated risks that requires a degree of courage not demanded in most other professional fields. It is this type of exemplary physician that a committee defends in conjunction with his legal counsel and insurer without whitewashing. On the other hand, grievance and defense committees are acutely aware of a few individuals in the profession who through sharp practices and financial gouging make necessary such a source of appeal for the occasional victim of their unethical conduct.

The handling of complaints in this latter group, professional conduct, poses a more difficult problem. Some patients complaining of a professional service rendered may present a cosmetic defect or functional disability, and may already have been told by another doctor that the treatment was less than should have been expected, and thereby responsible for the result. When this type of complaint is dealt with, it is sometimes necessary to tell the complainant that although the disability is an actual fact, the attending doctor is not responsible for the poor result. When the reverse is true the doctor and his lawyer and insurance company are informed of the evidence of negligence.

Our committee in Rhode Island serves, we believe, a constructive purpose, the integrity of which has been maintained throughout the years, by not approaching any case with a preformed conclusion that the doctor is right. To foster the opinion that a committee was overly favorable to the doctor would injure the committee's reputation for competence and fairness, as well as the society's public relations, which in this era are pretty well herniated from repeated strains. But when the physician has fulfilled all the requirements and legal obligations due his patient, no suit should arise. When it does, it is usually successfully defensible, and the committee has the obligation to inform such a patient the blame and criticism cast upon the doctor is neither justified nor deserved and that medical authority is available to support this opinion.

We are all subject to the vagaries of human frailty, but none less than the M.D. There are many days when he is confronted with problems that make him wish he had stayed abed. No one, I am sure will dispute the fact that the great majority of doctors are conscientious, hard working and devoted individuals, only by whose courage and determination has the rest of humanity fallen heir to the present day excellence of health, the best ever enjoyed by any generation since the creation of man.

To perpetuate this legacy we need everybody's help—doctors, nurses, patients, hospital administrators, lawyers, and most certainly that of the record librarian.

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PESTICIDES

A Review of Current Literature

STANLEY SPRAGUE, M.D.

The Author, *Stanley Sprague, M.D., of Pawtucket, Rhode Island, Chairman, Committee on Industrial Health of the Rhode Island Medical Society.*

THERE APPEARS to be no question that the use of pesticides in agriculture has greatly increased production, and brought better food to the world. It is also noted that these pesticides must be used in a definite safe manner to protect the general public from the poisonous effects which these same pesticides can cause. Research is constantly going on in this regard both by government and private laboratories.

The estimate of insect damage to agriculture is estimated at an annual loss to the United States alone of four billion dollars, but fifty-two cents is returned for each dollar spent on insecticides. Gains in production, supply and storage of food will have beneficent action on human nutrition and health.

Opinions based on extensive research are to the effect that insecticides do not cause any diseases or increased susceptibility to disease in man or animals. In one area alone, workers exposed for a period of five years to DDT showed no evidence of physical damage attributable to DDT.

It is now possible to determine DDT intoxication in human beings by the excretion of a metabolite DDA in the urine. Previously, biopsy of the fat was the only available method.

As regards the phosphorus compounds, there is still evidence that fruit sprayed heavily with this compound remain toxic to experimental animals for many months.

Standardization of specifications of each pesticide is being put into effect and will make for safety, as all tests and precautions will be used before offering these products to the general public. Every new product (products are offered in greater number than can be tested) will in future have a sort of "Seal of Approval" before the public gets it.

More than eighty economic poisons have been reported on as of April, 1955. Each is treated from the chemical formula, physiological action, dangerous acute and chronic doses for man; signs and symptoms; laboratory findings; pathology; differential diagnosis to the actual treatment recommended for each. Copies of such a list are available at your Rhode Island Medical Society Library for your study. Also, it is hoped that each case will be reported to your Medical Society should your practice include a suspected case of poisoning from pesticides.

In handling any suspected case from pesticides a most careful history is of paramount importance. It is important to know what pesticide is suspected, what if any other poison was involved, concentration of the material, period of exposure, onset of symptoms and the symptoms presented. A careful neurological examination is also a "must," as many of the newer pesticides have a syndrome predominantly neurological. Some of the pesticides produce liver and kidney damage without signs pointing to those organs.

Treatment—mostly symptomatic, as many times exact poison causing symptoms is not known.

1. Emesis and gastric lavage (if poison is taken internally).
2. Evacuation of gut (avoid oily substances for these are not good if organic solvent or halogenated insecticide is involved).
3. Thorough washing of eyes and body if there has been external contact with the poison—the physician is advised to wear rubber gloves while aiding patient.
4. Supportive therapy
   a. Sedatives—Sod. Pentobarb for acute poisoning because of its rapidity of action. Phenobarb used to maintain a prolonged level of sedation in persisting neural hyperexcitability or convulsions.
   b. Stimulants—Adrenalin (in vascular collapse) used only after careful consideration; contraindicated when halogenated hydrocarbon insecticides, even though patient may be in severe depression or coma.
   c. Transfusions—May be indicated except where pulmonary edema is already present. If blood not available, five per cent glucose or normal saline infusions indicated.
   d. Oxygen therapy — Administered to patients with cyanosis or respiratory difficulty. Patients with pulmonary edema re-

quire oxygen under positive pressure as well as postural drainage and dehydration therapy until the exudate is checked.

If the nature of the toxic agent is known there may, of course, be an available specific antidote. Even so, the general care of the patient may do much to insure his survival.

The continued development of more insecticides is needed as in many areas the pests against which it is directed have produced an immunity to the previously used material. A volume of material has been written about so many various pesticides that it would take far more space than this or any other journal to even begin to condense data on each poison used, nor would it not have touched on the many Industrial Solvents which are constantly with those of us whose medical work takes them within this sphere.

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THE BEGINNINGS OF MEDICAL EDUCATION IN RHODE ISLAND – PART I

concluded from page 502

anxieties of commerce, the privations, discontents, and despair of poverty, and various other causes of mental perturbation, induce directly or indirectly, a large proportion of the diseases to which we have referred." In 1848 he reported in the American Journal of the Medical Sciences his cumulative surgical experience. This included fifteen herniotomies with eleven recoveries, one successful lithotomy, ligation of the common carotid artery, extirpation of the eyeball, a number of cataract extractions and other procedures. This largely antedated the discovery of ether, his only anaesthetics being laudanum and brandy. During 1831 he had a brief tenure as Professor of Obstetrics at Jefferson Medical College. This was an unsatisfactory experience and he did not repeat it. His fame in Providence rests largely on his successful endeavors in promoting the Rhode Island Hospital. I shall refer to these matters later. In 1853 he became first vice-president of the American Medical Association.

(to be continued)

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Or, if capital gain was your objective, does your stock still offer attractive growth prospects? Would you fare better in some other security from now on?

These are just a few of the questions we can help you answer by reviewing your investments. It costs nothing. If your holdings look to be in good shape, we'll be frank enough to say so. If they're not, we'll submit recommendations for you to take or leave as you see fit. Fair enough? If you agree, why not stop in, write, or telephone us to help you now.

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DISTRICT MEDICAL SOCIETY MEETING
NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was called to order by Robert L. Bestoso, President, on June 1, 1955 at the Hotel Viking at 8:30 P. M. with twenty-one members attending.

The speaker of the evening was Dr. Frank Cutts, President of the Rhode Island Medical Society. He enumerated the various committees of the Rhode Island Medical Society with their respective functions. He also spoke about the Physicians Service Plan with all its present economic difficulties and the protective devices that were being developed for protection of the Plan. A lively period of questions and answers followed his speech.

The minutes of the last meeting were read and approved.

The application of Dr. Barbara Veit to the Newport County Medical Society was read and her membership approved by the members of the Society.

A motion was made that the Secretary of the Society write to the Washington office of the A.M.A. and ask for a special report on the Bricker Amendment and that the item be placed on the Agenda of the Society. This was seconded and passed. Another motion was made that the Secretary request the Secretary of the State Society to forward a complete report on the various District Society balloting on Social Security. This was seconded and passed.

A motion was made that the study of Physicians office signs, advertising displays and listings be referred to the Public Relations Committee in order that it comply with the State Committee on Public Policy and Relations. This was seconded and passed.

A last motion was made that the President appoint a Liaison Committee to the Physicians Service consisting of three members of the County Society. This motion was seconded and passed.

Meeting adjourned at 10:05 P.M.

Respectfully submitted,
José M. Ramos, M.D., *Secretary*

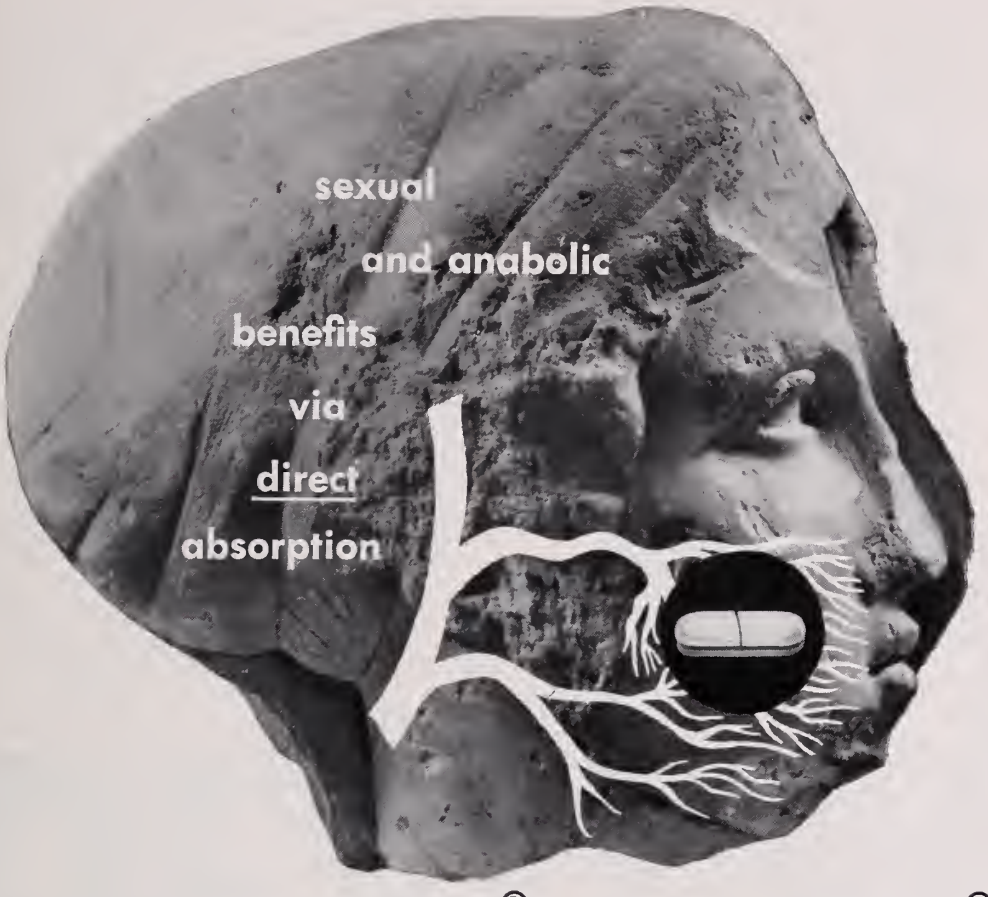
* * *

A special emergency meeting of the Newport County Medical Society was called to order by Dr. Robert Bestoso, president, at 9:00 P.M. at the Newport Hospital with twenty-four members attending.

This special meeting was called to order in order to clarify the misunderstanding concerning the status of the polio vaccine which was to be given on the following Wednesday to the school children of Newport.

Dr. Bestoso stated that he had been given clearance by Dr. McLaughlin of the State Board of

concluded on page 518



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NEWPORT MEDICAL SOCIETY

concluded from page 516

Health that same afternoon, and was informed that the polio vaccine which was to be used in this city had been given six million children since last year with no untoward results.

Dr. MacLeod stated that there was no dispute going on concerning the safety of the vaccine to be used in this city, but rather a question in regard to its distribution. He stated that it was considered a safe procedure by the Newport Board of Health.

Dr. Adelson made a motion to approve administration of the polio vaccine. This was seconded by the society and passed.

Respectfully submitted.

José M. Ramos, M.D., *Secretary*

BOOK REVIEW

THE REPRODUCTIVE SYSTEM by Frank H. Netter, M.D. The Ciba Collection of Medical Illustrations, volume 2. Ciba Pharmaceutical Products, Inc., Summit, N. J. 1954. $13.00

Frank H. Netter, M.D., physician, anatomist, and extraordinary medical artist has now completed his second full volume of illustrations. This volume comprises 270 pages of expert medical narration effectively punctuated by Dr. Netter's 235 superb illustrations.

Dr. John Rock has written the foreword to this volume, and the following quote expresses very well the unique coverage of this book. "Interestingly, 75% of the pages handsomely portray pathology of both primary and secondary male and female sex organs; that is disorders in their form and function. This visual and verbal description of pathological conditions is of considerable clinical value. Moreover it aids effectively in the acquisition of the physiological knowledge we need so badly. Disorders in the growth and function of organs serve to define by distortion and magnification the factors involved in normal development and behavior."

This book should be a *must* in the library of every practicing urologist and obstetrician-gynecologist. Actually greater stress is directed toward the urological and gynecological problems, but both normal and abnormal obstetrical conditions are adequately covered and illustrated. It is divided into fourteen sections with an acknowledged authority writing the text. The first five sections are concerned with the male reproductive system, and sections six-fourteen deal with the female reproductive system.

As previously mentioned the illustrations are superb, the descriptive text authoritative, and the pathological descriptions accurate. Over and above this a brief suggestion as to therapy is also included

Henry C. McDuff, Jr., M.D.

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1. Overall, J. C.: Southern M. J. 47:789, 1954. 2. Editorial: New England J. M. 246:111, 1952.
3. Grayzel, H. G., Heimer, C. B., and Grayzel R. W.: New York St. J. M. 53:2233, 1953.
4. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
5. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.
6. Turell, R.: New York St. J. M. 50:2282, 1950.

ON THE MEDICAL LIBRARY BOOKSHELVES

Books Received

The receipt of the following books is acknowledged and we thank the publishers for sending them. Unfortunately, not every volume received is reviewed either because of lack of space or because the reviewer to whom the book is assigned fails us.

Whether reviewed or not, the books are appreciated and are available at the Library.

The Adolescent Exceptional Child. A Realistic Approach to Treatment and Training. Proceedings of the 1954 Spring Conference of the Child Research Clinic of the Woods Schools held in New Orleans, Louisiana, April 9 and 10. Langhorne, Pa., 1954.

Collected Papers of the Mayo Clinic and the Mayo Foundation. Vol. XLVI, 1954. W. B. Saunders Company, Phil., 1955. $12.50.

The foreword states that "the material for the present volume . . . has been selected primarily with the interests of the general practitioner, the general surgeon and the diagnostician in mind."

Beyond the Germ Theory. The Roles of Deprivation and Stress in Health and Disease. Iago Galdston, Editor. A New York Academy of Medicine Book. Health Education Council, N. Y., 1954. $4.00.

Excerpta Medica. Section XVII. Public Health, Social Medicine and Hygiene. Vol. 1, no. 6. Amsterdam, 1955. Subscription $16.00.

Section XVII was published for the first time in January of this year. Articles appearing in the RHODE ISLAND MEDICAL JOURNAL are abstracted frequently in the various sections of Excerpta Medica.

Handbook of Medical Treatment by Milton J. Chatton, Sheldon Margen and Henry D. Brainerd. Lange Medical Publications, Los Altos, Calif., 1954. $3.00.

The 4th edition of the useful Handbook has been revised considerably and expanded in size.

The Medical Significance of Anxiety by Richard L. Jenkins, M.D. The Biological Sciences Foundation, Ltd., Wash., 1955. $1.00.

Doctor Jenkins says "The practicing physician has no choice as to whether or not to deal with the problem of anxiety. His only choice lies in whether he deals with it well or badly. This booklet is an endeavor to aid him to deal with it wisely."

New and Nonofficial Remedies 1955. Issued Under the Direction and Supervision of the Council on Pharmacy and Chemistry American Medical Association. J. B. Lippincott Co., Phil., 1955. $3.35.

This important reference book provides our members with information on relatively new drugs.

Physical Examination of the Surgical Patient by J. Englebert Dunphy and Thomas W. Botsford. W. B. Saunders Co., Phil., 1953. $7.50.

The publishers call this a "how to" book—*What* to look for, *how* to look for it and *what* your findings mean.

The Role of the Pituitary in Cancer. The Clinical Value of Pituitary Lipid Treatment by Henry K. Wachtel. The William-Frederick Press, N. Y., 1954. $2.00.

Tea. A Symposium on the Pharmacology and the Physiologic and Psychologic Effects of Tea. Henry J. Klaunberg, Editor. The Biological Sciences Foundation, Ltd., Wash., 1955. $1.00.

This is an interesting and enlightening discussion of a subject that has been written about throughout the ages. Tea, next to water, is the most consumed beverage in the world.

This Pace is *Not* Killing Us by J. I. Rodale. Rodale Books, Inc., Emmaus, Penn., 1954. $1.00.

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Attending Surgeon, Mount Sinai Hospital;
Clinical Professor of Surgery,
Columbia University

WEDNESDAY, OCTOBER 19, 1955, at 8:30 P.M.
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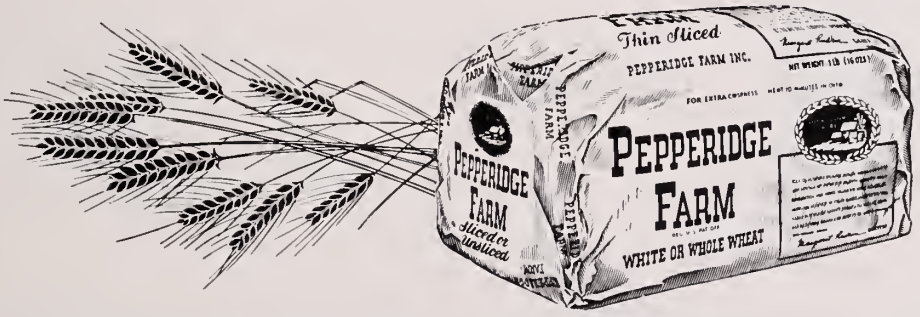
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The Public Health Service, with the approval of the President, is undertaking an expansion of its Inactive Reserve Corps. The purpose of this expansion is to provide a readily available mobile reserve force of doctors, nurses, engineers, and others to meet the impact of any national emergency.

Members of the Inactive Reserve Corps will not be called to active duty without their consent except in time of grave national emergency at which time every individual will have a defense role to play, locally or nationally.

Since modern weapons have become so diversified protective measures against these newly developed weapons need to be similarly diverse. Therefore, special training courses are in the process of being developed. These courses will be used in the training of groups of inactive reserve officers, on a voluntary — expenses paid — basis, from time to time.

The Public Health Service is just as interested in recruiting general practitioners, internists, surgeons, and other clinical specialists for the Inactive Reserve Corps as it is in recruiting public health trained physicians. Attached is a descriptive pamphlet which tells more about the Inactive Reserve Corps.

It will be appreciated if you will call this recruitment program to the attention of the members of your Society. Anyone interested in receiving an application for the Inactive Reserve Corps of the Public Health Service may obtain one by writing to the: Surgeon General, U. S. Public Health Service, Washington 25, D. C.

Additional information may be obtained from: Regional Office, Department of Health, Education, and Welfare, 42 Broadway, New York 4, New York.

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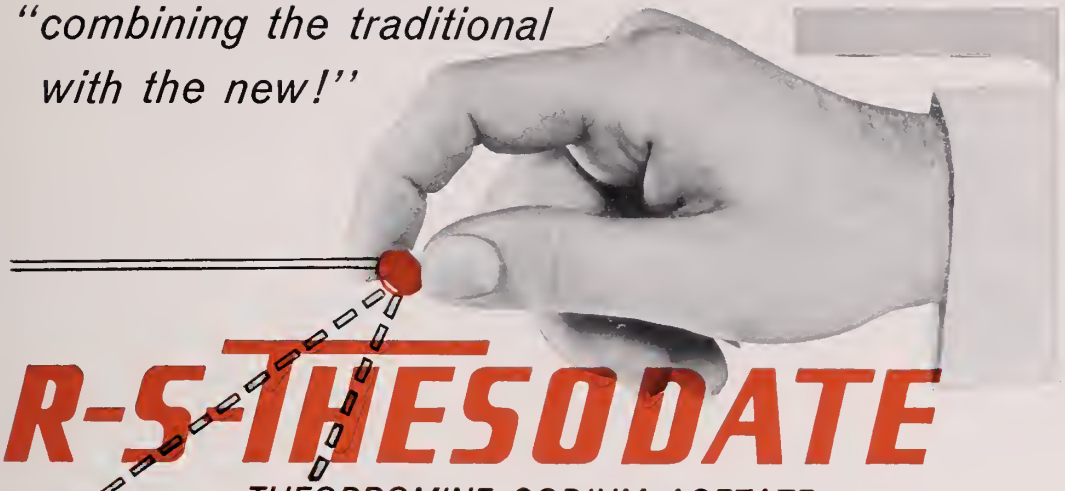
The U.S. Naval Air Station, Quonset Point, R.I., is recruiting to fill a vacancy for a Medical Officer (Occupational Health and Medicine), Grade GS-12, starting salary, $7,040 a year.

The experience requirements for this position are as follows: A degree of doctor of medicine and the completion of an approved full rotating internship or a full internship or residency in occupational health and medicine. In addition, one year of progressively responsible professional experience in the field of occupational health and medicine; or post graduate experience as a professor in such field of medicine in an approved school of medicine; or a full approved internship or residency in the field of occupational health and medicine; or one year of post graduate full-time study in such field in an accredited university or recognized institution or Certification by the American Board Certifying in such field by the Council on Medical Education and Hospitals of the American Medical Association.

Applicants are advised to report to the Industrial Relations Department, U.S. Naval Air Station, Quonset Point, R.I., for further details.

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CANCER IN RHODE ISLAND IN 1954

Annual Report of the Division of Cancer Control of the Rhode Island State Department of Health

THOMAS H. MURPHY, M.D.

The Author. *Thomas H. Murphy, M.D., Medical Director, Division of Cancer Control, Rhode Island State Department of Health.*

THE STATISTICS compiled by the Division of Cancer Control for 1954 reveal 416 more new cases reported than in 1953. In 1953 there were 1,943 new cases; in 1954 there were 2,359 new cases reported.

This may not represent an actual increase because the reporting was much better in 1954. The majority of the reports are sent in by hospitals where the patients are treated. Few cases are reported that are treated at home or in physicians' offices.

Physicians are reminded that cancer is a reportable disease and forms may be obtained at the Division of Cancer Control in the State Office Building.

The number of cancer deaths reported in 1954 was 1,432 compared to 1,339 in 1953. This is an increase of 93. The continued increase in the number of new cases and deaths proves to the medical profession that in spite of advances in many fields, cancer is still a baffling problem. The available weapons: surgery, X ray and radium are limited in their scope unless an early diagnosis is made before metastasis has taken place. The majority of cases reported from hospitals indicate that metastatic lesions were present at the time of initial treatment. Thus, we are reminded that the only hope for the majority of cancer victims is early diagnosis.

We must continue to urge people to have health examinations at least once each year in order to diagnose more cancer cases before they present symptoms. Let us continue the slogan "Every physician's office a Cancer Detection Center."

TABLE II

Analysis of Cancer by Age Group

— 1954 —

Age Groups	Males	Females	Total
0 to 9	8	3	11
10 to 19	15	6	21
20 to 29	21	33	54
30 to 39	40	88	128
40 to 49	87	192	279
50 to 59	219	289	503
60 to 69	332	344	676
70 to 79	274	229	503
80 to 89	80	78	158
90 to 99	9	5	14
Not stated	2	4	6
TOTAL	1088	1271	2359

TABLE IV

Rhode Island Cancer Deaths by Age Groups, 1954

Age	M	F	Total
1-9	5	6	11
10-19	8	2	10
20-29	3	2	5
30-39	25	19	44
40-49	55	60	115
50-59	123	121	244
60-69	242	198	440
70-79	214	173	387
80-89	85	75	160
90-99	9	7	16
TOTAL	769	663	1432

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TABLE I

Analysis of Cancer by Primary Site and Sex

— 1954 —

Primary Site	Male	Female	Total
Lip	18	3	21
Tongue	13	2	15
Mixed Salivary Gland Tumor (mal.)	2		2
Sublingual Gland	3	8	11
Floor of Mouth	10	2	12
Other parts of mouth, unspecified	8	1	9
Oral Mesopharynx	7		7
Nasopharynx	2	2	4
Hypopharynx	1	1	2
Pharynx, unspecified	3	1	4
Malignant Lymphoma	4	1	5
Esophagus	13	4	17
Stomach	83	51	134
Small Intestine	3	3	6
Large Intestine	143	143	286
Rectum	66	62	128
Biliary Passages and Liver	16	28	44
Pancreas	27	17	44
Peritoneum		2	2
Nose, Nasal Cavities and Accessory Sinuses	1	1	2
Larynx	26	2	28
Bronchus and Lung, primary	103	28	131
Bronchus and Lung, unspecified	1	2	3
Mediastinum	3	3	6
Breast	9	335	344
Cervix Uteri		111	111
Corpus Uterus		120	120
Chorionepithelioma		1	1
Ovary, Fallopian Tube and Broad Ligament		75	75
Unspecified Female Genital Organs		19	19
Prostate	157		157
Testes	10		10
Unspecified Male Genital Organs	6		6
Kidney	16	10	26
Bladder and Other Urinary Organs	77	24	101
Skin	122	86	208
Eyes	2	2	4
Brain and Other Parts of C.N.S.	7	11	18
Thyroid Gland	7	12	19
Adrenal Gland	1		1
Bone	9	8	17
Lymph Nodes (unspecified whether primary or secondary)	26	14	40
Unspecified Sites Reported as Carcinomatosis	37	45	82
Lymphosarcoma	1		1
Other Primary Lymphoid Tissue		2	2
Malignant Lymphoma	5	2	7
Hodgkin's Disease	19	6	25
Reticulosis	2		2
Lymphatic Leukemia	16	13	29
Acute Myeloid Leukemia	3	3	6
Acute Leukemia, unspecified type	2	1	3
Total	1088	1271	2359

1953—1943
New cases
Increase 416

continued on next page

TABLE III

Cancer Deaths in Rhode Island by Site, Sex and Age Group for 1954

Int'l Code No.	SITE	Male	Female	Total	Under 1 year		1 to 9		10 to 19		20 to 29		30 to 39		40 to 49		50 to 59		60 to 69		70 to 79		80 to 89		90 to 99	
					M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Malignant Neoplasm of Buccal Cavity																									
140	lip	1		1																					1	
141	tongue	7	3	10											1		2	2	2		1	1	1			
142	salivary gland	1		1															1							
143	floor of mouth	3		3											1		1		1							
144	other parts of mouth	4		4													1				2		1			
145	mesopharynx	2	1	3											1				1			1				
146	nasopharynx	1	2	3															1			1		1		
147	hypopharynx	1		1													1									
148	pharynx, unspecified	5	1	6													1		3		1	1				
	Malignant Neoplasm of Digestive Organs and Peritoneum																									
150	esophagus	13	3	16													2	2	3	1	6		2			
151	stomach	89	40	129									4	1	3	1	7	9	30	12	32	11	13	6		
152	small intestine	5	3	8													2		1	2	1		1	1		
153	large intestine	93	98	191									2	1	8	10	16	16	32	32	22	24	11	14	2	
154	rectum	51	31	82							1				3	2	5	2	18	14	15	7	9	5		
155	biliary passages and liver	12	22	34			1									2	2	3	7	10	3	6				
156	liver (secondary)	14	11	25												1	2	3	8	4	3	3	1			
157	pancreas	28	22	50									1		3		4	2	11	5	5	10	3	5	1	
158	peritoneum	4	2	6															3	1	1	1				
159	unspecified digestive organs	3	3	6													1			1	2			2		
	Malignant Neoplasm of Respiratory System																									
160	nasal cavities, middle ear, accessory sinuses	5	1	6													1	1	1		1		2			
161	larynx	15		15									1		1		3		8		2					
162	trachea, bronchus, lung (primary)	69	16	85									2	2	6		24	4	23	3	13	5	1	2		
163	lung and bronchus, unspecified	48	7	55											1	1	11	2	20	3	15	1	1			
164	mediastinum	2	0	2											1				1							
	Malignant Neoplasm of Breast and Genito-Urinary Organs																									
170	breast	1	120	121				1				1		2		23		29	1	25		26		11		
171	cervix uteri		31	31										1		4		7		10		8		1		
172	corpus uteri		6	6														1		2		2		1		
174	uterus, unspecified		26	26										1		1		6		8		9		1		
175	ovary, fallopian tube, broad ligament		48	48										3		6		8		20		9		1		
176	other and unspecified female genital organs		4	4																		2		2		
177	prostate	78		78						1						3		4		20		30		18		2
178	testes	3		3									1			1						1				
180	kidney	17	9	26						1			3	1		2	3	1	5	2	4	2	1	1		
181	urinary bladder and other urinary organs	26	19	45													3	1	9	6	8	6	6	6		
	Malignant Neoplasm of Other and Unspecified Sites																									
190	skin (melanoma)	1	2	3															1	1		1				
191	other malignant neoplasms of skin	3	7	10														1	2	1		3	1	1		
193	brain and other parts of C.N.S.	15	8	23				3					1	1	1	1	6	3	4	1		2				
194	thyroid gland	1	3	4								1			1							2				
195	other endocrine glands	2		2											1						1					
196	bone	11	6	17				1	1	1			1				1	1	1	1	4	2	2			1
197	connective tissue	2	2	4				1							1						1	1				
	Neoplasms of Lymphatic and Hematopoietic Tissues																									
198	secondary and unspecified malignant neoplasms of lymph nodes	5		5											1		1		1		1		1			
199	other and unspecified sites	55	65	120									2	4	6	4	10	8	10	21	19	15	7	12	1	
200	lymphosarcoma and reticulosarcoma	13	9	22						1		1	2		3	1	1	2	1	1	3	5	1			
201	Hodgkin's disease	16	3	19								1	1		3		4		4	1	3	1		1		
202	reticulosis	7	4	11			1		1				1					1	4	3						
203	multiple myeloma	1	7	8											1			2		2		3				
204	leukemia and aleukemia	35	18	53			1	2	3	1			3	2	4	1	4	4	4	5	14	2	1	1	1	
205	mycosis fungoides	1		1																			1			
	Total	769	663	1432																						

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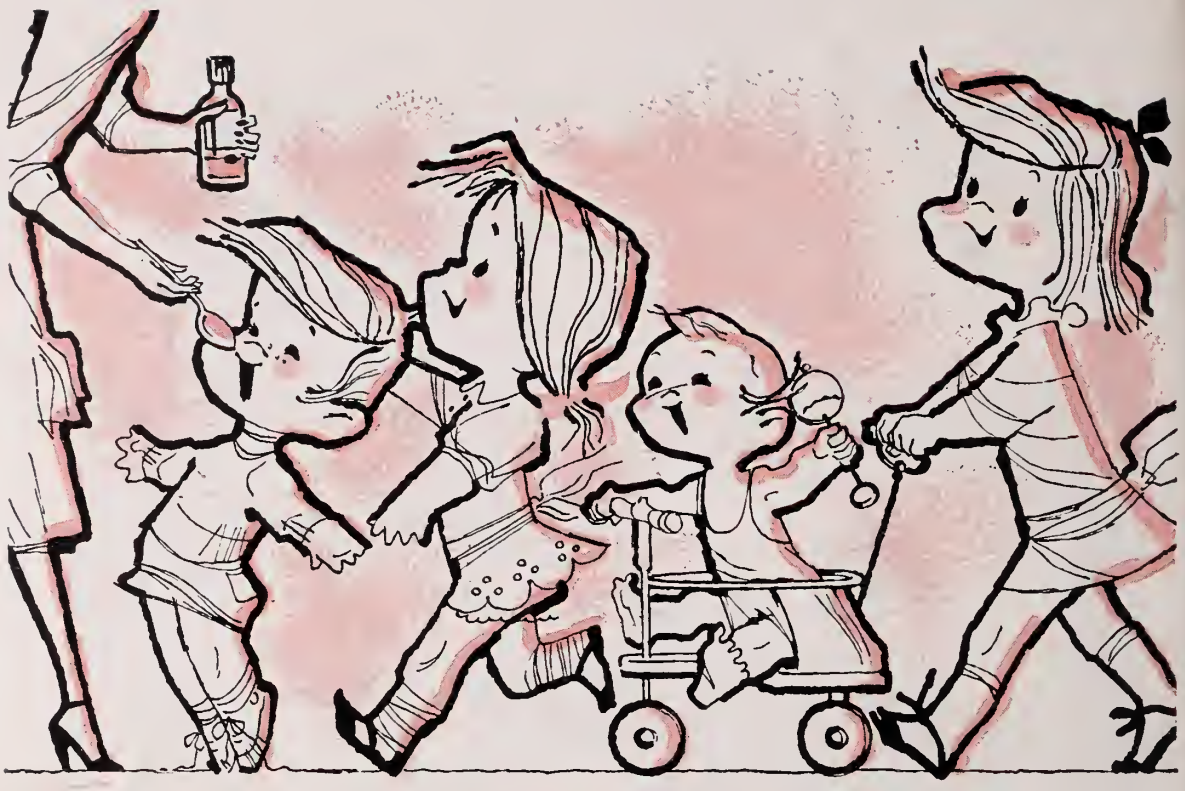
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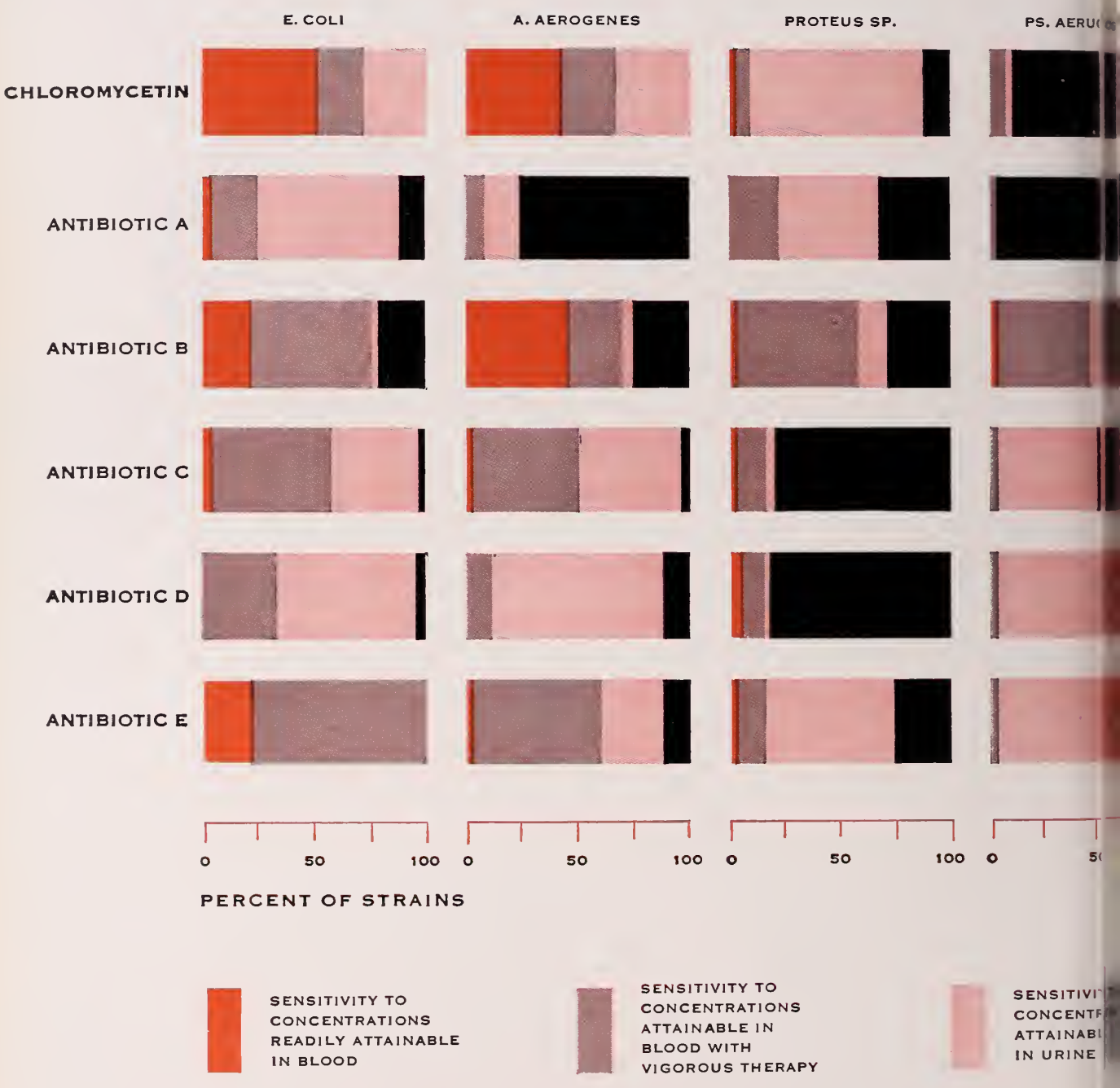
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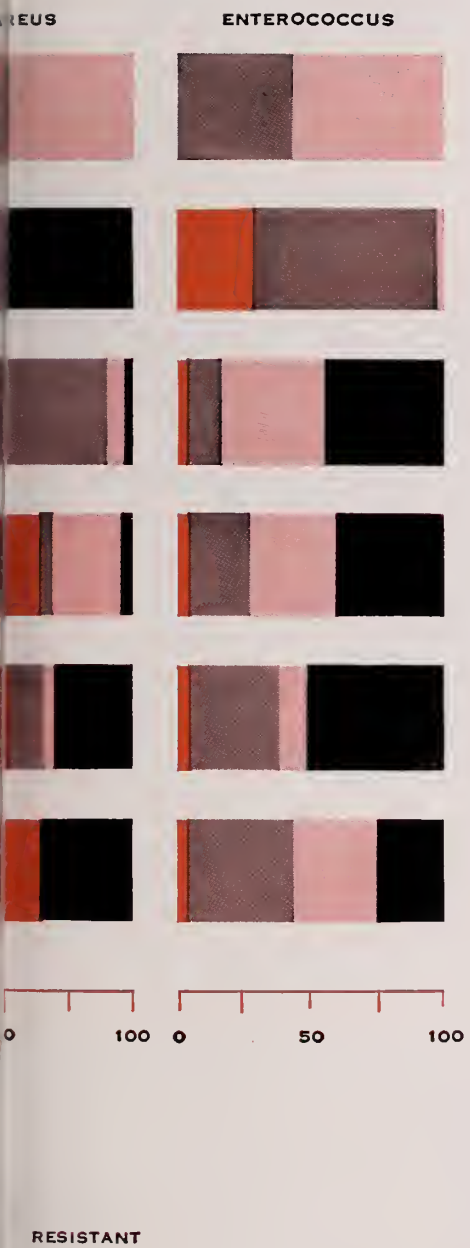
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*Adapted from Kass, E. H.[9]

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References (1) Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305, 1955. (2) Kutscher, A. H.; Seguin, L.; Lewis, S.; Piro, J. D.; Zegarelli, E. V.; Rankow, R., & Segall, R.: *Antibiotics & Chemother.* 4:1023, 1954. (3) Clapper, W. E.; Wood, D. C., & Burdette, R. I.: *Antibiotics & Chemother.* 4:978, 1954. (4) Sanford, J. P.; Favour, C. B.; Harrison, J. H., & Mao, F. H.: *New England J. Med.* 251:810, 1954. (5) Baleh, H. H.: *Mil. Surgeon* 115:419, 1954. (6) Sanford, J. P.; Favour, C. B., & Mao, F. H.: *J. Lab. & Clin. Med.* 45:540, 1955. (7) Felshin, G.: *J. Am. M. Women's A.* 10:51, 1955. (8) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (9) Kass, E. H.: *Am. J. Med.* 18:764, 1955. (10) Stein, M. H., & Gechman, E.: *New England J. Med.* 252:906, 1955. (11) Yow, E. M.: *Postgrad. Med.* 17:413, 1955.

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Clinical sequelae of protein malnutrition include kwashiorkor and liver disease.[1] In kwashiorkor the caloric intake may approximate normal, but the dietary protein is less than the necessary minimum in quality and quantity. Many tropical diets supply 10 to 15 per cent of the calories in the form of vegetable protein. Kwashiorkor may follow infections, especially of the gastrointestinal tract. Diets below 10 per cent in protein calories lead to frank protein malnutrition, including signs and symptoms of kwashiorkor.

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1. Gyorgy, P.: On Some Aspects of Protein Nutrition, Am. J. Clin. Nutrition 2:231 (July-Aug.) 1954.
2. Davies, J.N.P.: Kwashiorkor. Trans. Ninth Conf. on Liver Injury, Josiah Macy, Jr. Foundation, 1950, p. 109.
3. The National Food Situation, Washington, D. C., Agricultural Marketing Service, United States Department of Agriculture, Oct. 29, 1954. p. 4.

The nutritional statements made in this advertisement have been reviewed and found consistent with current medical opinion by the Council on Foods and Nutrition of the American Medical Association.

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*Combes, F. C. & Canizares, O.: New York St. J. Med. 52:706, 1952; Marsh, W. C.: U. S. Armed Forces M. J. 1:1045, 1950.

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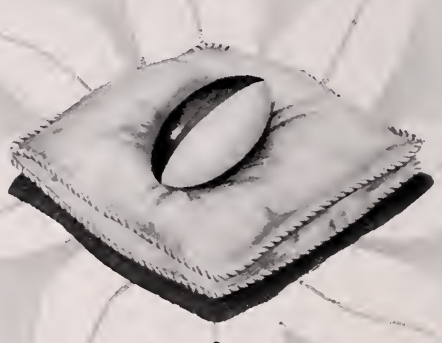
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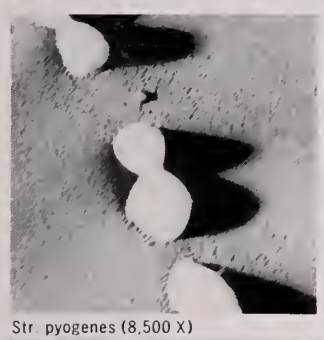


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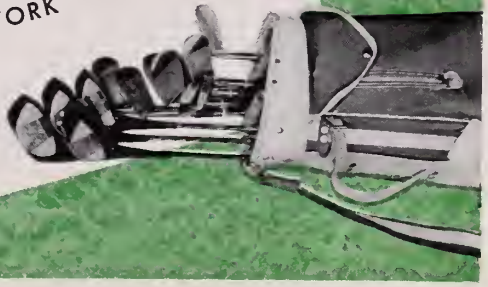
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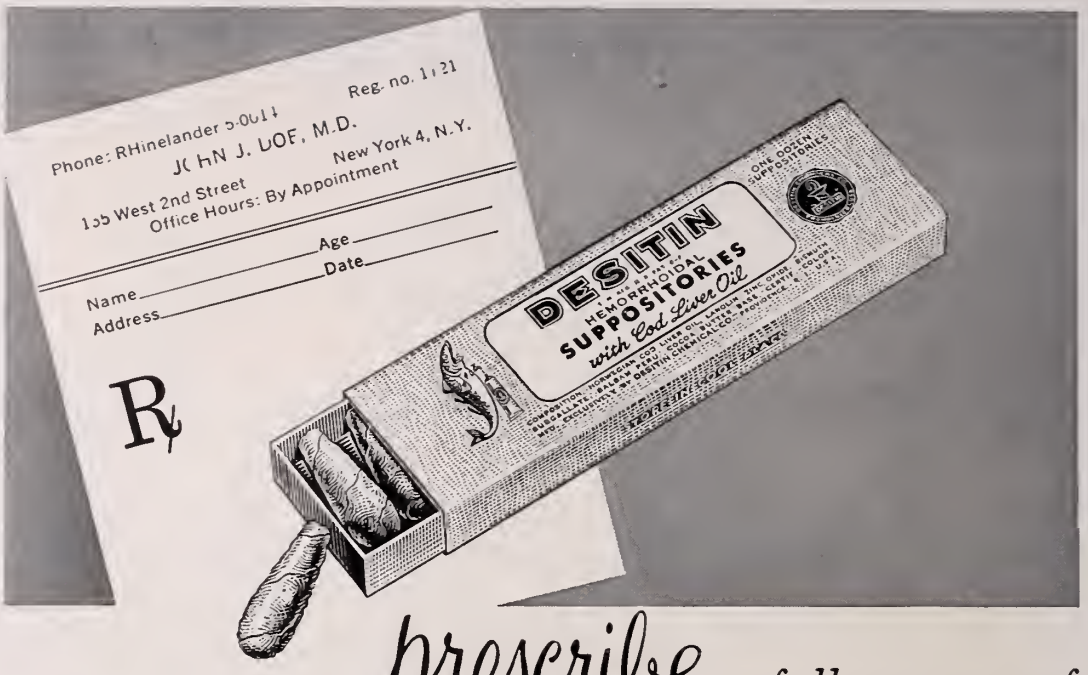
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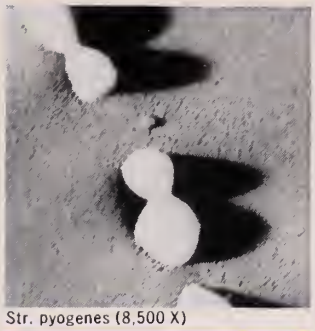
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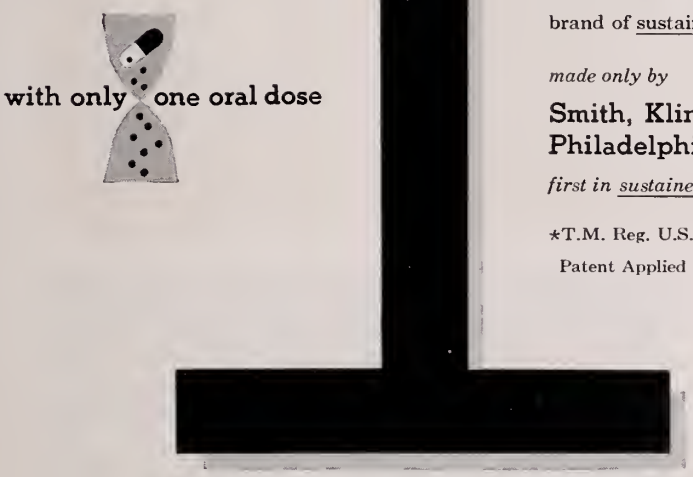
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SEGMENTAL ARTERIAL OCCLUSIONS TREATED WITH RESECTION AND GRAFTING*

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THE SURGERY of arterial occlusive disease has advanced rapidly during the past few years. It now appears that replacement of occluded segments with grafts offers the best possibility for success. The ideal graft has probably not yet been found, but it seems likely that flexible plastic tubes will prove to be the most satisfactory in the future. Recent experimental reports by Deterling, et al[1] and Hufnagel[2] are encouraging. At the present time, we have no clinical experience in humans with artificial blood vessel prostheses. Because of the availability of an arterial bank, our experience is limited to the use of homologous arterial grafts and autogenous vein grafts. In the use of autogenous vein grafts, we have employed the methods described by Julian and Dye.[3] Homogenous vein grafts have not been required to date. The arterial bank employs the frozen state method of preservation of homologous arteries described by Gross.[4]

The ideal candidate for resection and arterial grafting described by Robb,[5] Julian and Dye,[3] and Szilagyi,[6] is the patient with pure segmental arteriosclerotic occlusion and with intermittent claudication as the primary symptom. Rest pain, trophic changes such as ulceration and gangrene represent artereolar involvement and therefore have been said to represent contra-indications to surgery.

In the patients discussed in this report, segmental occlusions were found to be associated with generalized arteriosclerotic changes, and no pure segmental blocks were identified. One of the patients had intermittent claudication as the primary complaint and the remainder had advanced signs of artereolar disease which includes severe rest pain, ulceration, and gangrene.

The purpose of this study is to evaluate the results of arterial grafting when these methods are applied to the advanced arteriosclerotic patient with proven segmental occlusions. With the exception of one, all of these patients were facing inevitable amputation at the time of arterial grafting. Thrombo-endarterectomy has been abandoned except for short segment iliac occlusions.

Methods

Femoral Arteriography and Aortography. Angiographic techniques are carried out under intravenous Pentothal and Leucine sensory spinal anesthesia. A fractionation technique of obtaining X-ray exposures is used as described by Langsam and Wilansky.[7]

Aortography is performed using a two-needle (18 gauge thin) technique for simultaneous injections. We employ Sodium Acetrizoate (Urokon Sodium) 70% as the radiopaque medium. Femoral arteriography is carried out by the percutaneous route using an 18 gauge thin needle and 35% Urokon solution. X-ray films are exposed at three- to four-second intervals. If satisfactory visualization of the popliteal and anterior and posterior tibial arteries is not obtained on the first injection, a repeat injection is carried out. If satisfactory visualization of the femoral and lower leg vessels is not obtained by fractionation aortography, femoral arteriograms are obtained.

Operative Technique. Positioning of the patient on the operating table has varied depending on the site of the block. The supine position with flexion of the involved extremity employing the Henry approach to the vessels has been used largely. An exaggerated Sims position with the opposite extremity hyperflexed on the trunk has proved a very satisfactory approach to the femoral and popliteal vessels. In half of the cases, after division above and below the block, the occluded segment has been

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*From the Boston University Teaching Service (Third Surgical), Boston City Hospital. Presented at the Reunion Day of the St. Joseph's Hospital Staff Association, at Providence, Rhode Island, September 7, 1955.

ligated at each end and left in situ. In the other half, the occluded segment was resected for technical reasons. End-to-end anatomoses employing an everting interrupted suture of #00000 silk were used in all but one case. In this instance, a shunt type of graft with end-to-side anastomosis proximal and distal to the occlusion was employed. Where autogenous saphenous vein was used, the vein was reversed prior to implantation. The segments replaced are shown in Table I. Anticoagulant therapy was not used as a routine postoperative measure.

TABLE I
Segments Replaced or Bypassed

Aortic bifurcation	1
Common Iliac to Femoral	1
External Iliac to Common Femoral	1
Superficial Femoral	5
Femoral to Popliteal	1
Subclavian	1

Type of Grafts. The distribution of types of graft employed is seen in Table II. Autogenous saphenous vein was used in six patients. However, in one of these because of incomparability at the upper end, it was necessary to insert a short segment of superficial femoral vein in order to complete the anastomosis. Homologous artery was used in four instances and this was obtained from the artery bank in frozen state. These vessels are taken in the autopsy room under unsterile conditions and after being placed in a double-sealed Polyethylene envelope quick frozen in dry ice and placed in the deep freeze. While kept in the frozen state, the vessels are sterilized under the two million volt cathode ray machine at Massachusetts Institute of Technology. The graft is prepared at operation by thawing in normal Saline and ligating all branching vessels with #00000 silk.

TABLE II
Type of Graft and Results

	Good	Failure
Autogenous SaphenousVein	4	2
Homologous Artery	2	2

Age of Patient. The patients varied in age from 52 to 76 years with an average age of 64 years. There were eight males and two females in the series.

Report of Cases

The following case summaries will serve to indicate the multiplicity of problems involved.

Case I. J.D. A sixty-five-year-old white male diabetic of long standing entered the hospital on May 3, 1955, with wet diabetic gangrene of the left third toe of five weeks' duration. On a previous admission two years ago, left lumbar sympathectomy had been recommended but refused by the patient. A lumber sympathetic block produced very slight warming of one to two degrees on the left side. Left lumbar sympathectomy and amputation of the third toe was carried out on May 11th without appreciable improvement in the circulatory status of the foot. Left femoral arteriogram at the same time revealed an arteriosclerotic occlusion of the entire superficial femoral artery from the profunda take-off to the popliteal. Because of arterial insufficiency in the opposite foot, an aortogram was performed on May 25th which again showed the occlusion of the superficial femoral on the left. There was generalized arteriosclerosis with considerable narrowing of the right superficial femoral artery but the vessels were grossly patent. The amputation site of the left third toe remained necrotic and septic and gangrene spread to involve the second toe. On June 6, 1955, the left superficial femoral artery was replaced from the origin of the profunda to the popliteal with an autogenous saphenous vein graft. The occluded artery was left in situ. Post-operatively, the left foot was warm and pedal pulses have continued until the present. The gangrenous left second toe was amputated on June 19, 1955. In spite of the return of pedal pulses and warming of the foot, the already present infection and necrosis at the amputation stumps failed to heal. On August 19, 1955, a left transmetatarsal amputation was performed coincidental with a right lumbar sympathectomy. A satisfactory result has been obtained thus far.

In view of the advanced state of artereolar disease associated with long-standing diabetes, this man was most certainly facing mid-thigh amputation prior to arterial grafting. Trans-metatarsal amputation would probably have failed without this procedure.

Case II. H.N. A sixty-year-old white male tabetic retired policeman entered the hospital on March 28th because of large gangrenous trophic ulcers over both lateral malleoli. His physiological age was estimated at approximately eighty. He had been completely incapacitated at home in a chair for the past two years. He had been unable to walk because of tabes and the trophic ulcers of one year's duration. In spite of multiple operative procedures including bilateral lumbar sympathectomy and repeated skin grafting of the ulcer areas, healing failed to take place. Left femoral arteriogram on April 5, 1955, showed occlusion of the left distal femoral and popliteal arteries. This vessel was replaced with an autogenous saphenous vein graft without resection of the block segment on June 23, 1955. Immediately following operation, there was marked improvement in the temperature of the foot and the anterior tibial pulse was felt and has continued. Subsequently the ulcer over the left lateral malleolus was grafted and has almost completely healed at present. Unfortunately, arterio-

grams of the right leg show generalized narrowing but no discrete occlusion. The trophic ulcer over the right lateral malleolus has increased in size and a large ulceration has now occurred over the heal of the right foot.

Although the follow-up interval is only ten weeks, preservation of the left leg appears to have been accomplished. However, the right leg will undoubtedly come to amputation in the near future.

Case III. H.N. A fifty-four-year-old white male who entered the hospital on June 22, 1955, because of severe ischmic rest pain in the right foot of one month's duration. Nine years previously, a right lumbar sympathectomy is said to have been performed for "Berger's Disease." One year prior to admission, the patient had had a cerebral vascular accident with a transient right hemiplegia associated with hypertension. Since onset of symptoms one month ago, he had been unable to walk far enough to determine the presence of intermittent claudication. Examination revealed coolness of the right foot. There were no pulses palpable below the femoral on the right side. A right femoral arteriogram on June 23, 1955, revealed a five-inch block of the right superficial femoral artery. On June 29, 1955, an autogenous saphenous vein graft to the right femoral artery was carried out without resection of the block segment. Post-operatively, there was symptomatic improvement and pedal pulses were noted for the first six post-operative days. At this time, the wound was found to be grossly septic. Deteriorization of circulation occurred and the right foot gradually became gangrenous. Mid-thigh amputation was performed on August 8, 1955. The amputated specimen showed patency of the autogenous vein graft, but thrombosis of the popliteal and tibial vessels.

What appeared to be a satisfactorily functioning vein graft for six days became a failure in this case probably due to massive sepsis which resulted in distal thrombosis.

Case IV. G.G. A seventy-year-old white female diabetic of thirty years' duration. She entered the hospital because of infection of the left great toe and marked arterial insufficiency of the left as well as the right foot. Eight years previously, amputation of the right fourth toe and left second toe had been performed because of infection. Examination revealed infection of the left great toe and absence of pedal pulses bilaterally. A left lumbar sympathectomy had been performed in 1944 and she had had a previous hospital admission for myocardial ischemia one year previously. On February 24, 1955, a left femoral arteriogram revealed an occlusion of the distal left femoral artery. This was resected and replaced with an autogenous vein graft on March 1, 1955. Post-operatively, there was considerable warming of the left leg and foot and healing of the skin lesions was taking place. She suddenly expired on the sixth post-operative day and was thought to have had a myocardial infarction. However, autopsy was not obtained.

This patient was accepted as an extremely poor cardiac risk for surgery. Since she was facing a major amputation, arterial graft was thought worth while. At the time of sudden death, the graft was functioning well and healing of the long-standing infection of the foot was taking place.

Case V. M.McD. A seventy-four-year-old diabetic of long standing entered another hospital because of severe ischemic pain of the entire right foot. She also had a 3 cm. deep gangrenous ulcer of the right heel which was extremely painful. Physical examination revealed a thin cyanotic extremely tender right foot with absence of peripheral pulses below the femoral. On January 1, 1955, a right lumbar sympathectomy was performed which afforded absolutely no relief in the rest pain. The gangrenous ulcer of the heel spread and deepened considerably. Right femoral arteriogram on January 12, 1955, revealed complete occlusion of the superficial femoral artery. However, a popliteal vessel of satisfactory caliber was finally visualized after repeat arteriograms. On January 26, 1955, the entire right superficial femoral artery was replaced with an autogenous saphenous vein graft. The saphenous vein at the proximal anastomosis was too small and therefore a segment of superficial femoral vein was used to make up the proximal end of the graft and the proximal anastomosis. Following operation, rest pain was completely relieved. There was marked increase in the temperature of the foot with the color returning to normal. Pedal pulses could not be felt. At the time of discharge from the hospital four weeks later, the heel ulcer had almost completely healed and the patient continued to be free of pain.

With symptomatic improvement and healing of the trophic ulcer as the only criterion for considering this a satisfactory result, it must be pointed out that this patient's limb has been preserved until the present. This is an eight-month period of follow-up and she most certainly faced mid-thigh amputation prior to arterial replacement.

Case VI. R.C. A fifty-two-year-old white male was first seen at an out-of-town hospital at midnight on May 23, 1954. At 3:30 P.M. that afternoon, he had been awakened while sitting in a chair by a severe cramp in the left foot. When admitted to the hospital two hours later, the left leg was cold and cyanotic to the level of the knee. At this time, the examining physician could obtain no pulses below the left femoral. When seen at midnight, no pulses were present below the inguinal ligament on the left. An iliac pulsation could be felt. There

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was numbness and loss of sensation and coldness to the level of the knee. There was no history of previous myocardial infarction or auricular fibrillation. Pre-operative impression was that an acute arterial thrombosis of the left iliac and common femoral artery had taken place. At operation, the distal left iliac and common femoral arteries were found to be occluded by fresh thrombus at the site of a long arteriosclerotic plaque. The artery was resected from the bifurcation of the iliac to just proximal to the profunda femorus artery. An autogenous saphenous vein graft was used. However, prior to completing the distal anastomosis, a retrograde flush with heparin solution was attempted at the posterior tibial artery at the ankle. This was unsuccessful and no solution could be forced through the bloodless posterior tibial artery. The reason for this became apparent on exploring the popliteal artery which was found to be completely occluded and apparently of long-standing. Therefore, the distal anastomosis was completed, and a left lumbar sympathectomy performed. Post-operatively, there was considerable improvement in the circulation of the foot. The color became pink and the temperature increased. However, where the arteriotomy had been performed for retrograde flush just posterior to the medial malleolus, the wound edges became gangrenous and gradually spread. Three months later, a left mid-thigh amputation was performed.

This case brings out the generally accepted poor prognosis for sudden thrombotic occlusion of a major artery. The results might have been different had there not been a previous segmental occlusion of the popliteal artery. This extremity might have survived had not gangrene developed at the site of posterior tibial artery retrograde flush wound. This represents an unforeseen technical error.

Case VII. C.C. A sixty-three-year-old white male who entered the hospital because of increasing coldness of the left foot on March 22, 1955. The foot had become red and tender a few days before admission. There was a past history of repeated admissions to the hospital for acute and chronic alcoholism and two years previously, a cerebral vascular accident left him with complete aphasia and dysarthria. Examination revealed marked tenderness in the left foot with rubor and cyanosis on dependency. On March 23, 1955, translumbar aortogram revealed complete occlusion of the left external iliac artery. Left lumbar sympathectomy performed on March 28th afforded only slight relief of pain and no objective evidence of improvement in circulation. Resection of the left common iliac and external iliac artery was carried out from 2 cm. distal to the aortic bifurcation to just proximal to the origin of the profunda femorus artery on May 9, 1955. Replacement was accomplished with a long arterial homograft. Following operation, there was complete relief of symptoms. The left foot became warm and a good posterior tibial pulsation could be felt. Gangrene of the left great toe which had occurred prior to arterial grafting gradually healed by the time of discharge on June 29, 1955. During this hospitalization, a right lumbar sympathectomy was also carried out for arterial insufficiency of the right leg with considerable improvement. Because of persistent posterior tibial pulsation on the left, post-operative arteriograms were not performed.

By all standards, this man represented a poor risk for surgery of any kind. However, a good result has been obtained over a five-month follow-up.

Case VIII. S.S. A sixty-eight-year-old white male whose primary complaint on March 9, 1955, was intermittent claudication of two years' duration. Calf muscle pain occurred on the left after five minutes of walking and on stopping, the pain lasted for approximately five minutes before relief was obtained. During the previous year, he had been treated with Priscoline and had had twenty-eight chiropractic treatments without benefit. On examination, both feet were cool and on the left side, there was dependency cyanosis. Dorsalis pedis and posterior tibial pulsations were absent on the left. A faint popliteal and a good femoral pulse was present on the left side. Good pedal pulses were obtained on the right. Left femoral arteriogram performed on March 15, 1955, revealed an incomplete occlusion of the left superficial femoral artery. A fine stream of dye could be seen passing through the partially blocked vessel. The popliteal artery distal to the partial block was considered satisfactory for grafting. On March 24, 1955, a shunt type of homologous arterial graft was inserted without disturbing the superficial femoral or the collateral circulation. The proximal end-to-side anastomosis was placed just distal to the profunda femorus artery take-off. The distal end-to-side anastomosis was placed in the proximal popliteal artery. It should be noted that the femoral artery contained multiple arteriosclerotic plaques and it was difficult to find satisfactory sites for the end-to-side anastomoses. Immediately following operation, a good posterior tibial and a faint dorsalis pedis pulsation could be felt. These have persisted over the follow-up period of the seven months. Anti-coagulant therapy was not used. The primary complaint of intermittent claudication had been completely relieved on this side. He continues to smoke and is now complaining of intermittent claudication on the opposite or right side. In spite of the good result on the left, he refuses further surgery for the right side.

The pre-operative arteriographic findings in this case suggested a pure arteriosclerotic occlusion.

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LONG-TERM SURVIVAL IN CANCER OF BREAST, STOMACH, AND IN MALIGNANT MELANOMAS*

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THE TUMOR CLINIC of the Rhode Island Hospital has been in existence since 1932. It furnishes consultation service for the treatment of patients referred by private physicians of the local medical community. In addition, it is a follow-up clinic for treated ward cases. These cases are of a less favorable type than that seen in the large university medical clinics because these patients usually have far advanced disease when first seen. They are poorly educated, in the lower economic levels, and all too frequently do not recognize the need for medical care until it is too late. They have been treated in several hospitals by surgeons of varying degrees of technical skill and thoroughness. Nevertheless, we have found a considerable number of long-term survivals in patients with malignant neoplasms and are reporting our experiences in cases of breast cancer, stomach cancer and malignant melanoma. We define "long-term survival" as a life span of five years or more, from the time of diagnosis and treatment.

There are 541 cases of breast cancer registered in the tumor clinic for the years 1931-48. Of these, 509 cases can be used. The remaining 32 cases are discarded because of inadequate follow-up. Twenty-seven per cent (146 cases) have survived from 5 to 29 years after diagnosis and treatment. There are 87 cases in the 5-10-year groups, 38 cases in the 10-15-year group, 14 cases in the 15-20-year group and seven cases in the 20-year or more group.

TABLE I

Time	*Cases*	*Living*	*Dead*	*No Follow-up*
5 + Years survival	87	20	49	18
10 + Years survival	38	17	16	5
15 + Years survival	14	5	9	0
20 + Years Survival	7	4	3	0
Totals	146	46	77	23

Now, what happened to the long-term survivors? Seventy-seven of the 146 are dead. Twenty-three are lost to further follow-up study after survival for a number of years. Twelve have died, either due to causes other than cancer, or of unknown causes. This emphasizes the importance of the autopsy in determining the eventual outcome of these cases since death is not necessarily due to the original carcinoma.

We have confirmed the diagnosis in 128 out of 146 cases by review of the microscopic slides. The slides are not available in the remainder, but the pathology report or the case follow-up has enabled us to accept the remaining 18 cases as true cases of cancer of the breast.

In order to determine whether there is a trend for increasing long-term survival after treatment for cancer of the breast, we have reviewed the experiences in groups of five years.

TABLE II

Time	*Cases*	*5 + years survival*	*Per cent*
1932-1935	142	20	14
1936-1940	176	50	28
1941-1945	160	50	31
1946-1948	98	25	25

Table II shows a vast improvement in long-term survival after the first four years of the tumor clinic but in the subsequent 13 years a plateau had been reached.

Twenty-seven per cent long-term survival is not a very high percentage. This is a gross percentage rate since it includes cases with death due to other causes than cancer of the breast. Some of the cases were operated on at other hospitals and then referred to our clinic for terminal care and follow-up. (188 patients were terminal or initially operated at other hospitals; if eliminated, the long-term survival rate is 45 per cent.) It would be interesting to know the over-all experience of cancer of the breast in this hospital, including private patients, as well as tumor clinic patients. This information will become available by the establishment of a hospital cancer registry.

There are reports in the literature that the well-differentiated tumors of the breast tend to have a better prognosis than the undifferentiated tumors. We reviewed the histopathology of our cases of long-term survival and found no constant feature

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*Presented at the meeting of the Rhode Island Hospital Research Day, November 10, 1954.

to enable us to differentiate the cases that survived five years from those that survived 15 years. For the most part, the tumors were active, moderately undifferentiated and infiltrating lesions. It is our impression that the majority of breast cancers shows a similar histologic pattern and that this makes it difficult to grade them and use groups of such cases to evaluate prognosis. The exceptions are: intraductal carcinoma, Paget's disease of breast, colloid carcinoma, medullary carcinoma or the highly anaplastic carcinomas. These, however, make up only a small percentage of the tumors.

It is interesting to note that in 69 cases of long-term survival, in which lymph nodes were demonstrated in the axillary dissection, 38 (53 per cent) of them had metastases. In 204 cases of short survivals, in which lymph nodes were demonstrated, 129 (63 per cent) had metastases. This emphasizes the advanced stage of disease in our tumor clinic cases.

The long-term survival in cancer of the breast in young and older women was similar. Twenty-five per cent of the women 23-40 years of age, with cancer of the breast, lived for five or more years. Twenty-eight per cent of women over 40, with cancer of the breast, lived for five or more years. Thus, long-term survival in the younger group was similar to the older. These figures are statistically significant, as shown by use of the chi-square test.

Harrington[1] has reported on 5,548 patients with carcinoma of the breast. He noted that the five-year survival in young women between 20 and 29 years of age was 60.2 per cent, whereas with women in the forties it was 50.2 per cent and in the fifties it was 47.1 per cent. He has reported that there are less patients with cancer of the breast in the earlier decades of life, which may possibly alter the significance of these statistics. Nevertheless, it would seem that the disease does not have a worse prognosis in the younger age groups than in the older. We are excluding the cases of cancer of the breast associated with pregnancy, which has a poor prognosis.

We have no cases of long-term survivals in cancer of the male breast. This bears out the general impression of the poor prognosis of this disease in the male. It has been suggested by Somerville[3] that the prognosis is not as good as in the female because of the rapidity of local and distant spread owing to the limited breast tissue; the tendency for men to ignore the lump; and the occasional failure of the physician to detect early carcinoma and realize its seriousness.

There are only three cases of bilateral breast cancer with long-term survival. It is difficult to determine whether these are cases of metastases from one breast to the other, or whether they are bilateral primary breast cancer. Of the three cases, two had long-time intervals before the appearance of tumor in the opposite breast. This possibly represents a double primary incidence of disease but it is admittedly equivocal.

Harrington[1] has reported a 2.4 per cent incidence of bilateral breast cancer. He had a 35 per cent survival rate for 15 years or more. We have too few cases to be statistically significant, but it should be noted that in the three cases, two lived for six and eight years respectively after the second operation.

In general, it seems fair to say that the long-term survival in bilateral breast cancer is less likely than in unilateral disease. However, the condition is not, invariably, rapidly fatal.

Among the long-term survivors are 11 cases with recurrence. (Table III) These occurred from two to ten years after the original operation and lived one to twelve years after. This emphasizes that five-year survival without recurrence is not a guarantee of cure. Four of our long-term survivors had multiple carcinomas. (Table IV)

TABLE III

Recurrences in Long-Term Survival

		Interval	*SurvivalAfter*	*Total Survival Time*
1.	42-5684	3 yrs.	3 yrs.	6 yrs.
2.	44-6494	7 yrs.	1 yr.	8 yrs.
3.	45-6863	5 yrs.	1½ yrs.	6½ yrs.
4.	46-7221	7 yrs.	1 yr.	8 — alive
5.	34-1441	13 yrs.	2 yrs.	15 yrs.
6.	48-8671	10, 13	7 yrs.	20 yrs.
7.	39-420	2 yrs.	4 yrs.	6 yrs.
8.	40-4453	2 yrs.	12 yrs.	12 — alive
9.	41-5206	9 yrs.	6 yrs.	15 yrs.
10.	43-5887	2 yrs.	3 yrs.	5 yrs.
11.	47-7651*			5 — alive

*Date of removal of initial tumor not known.

In summary, we have 146 out of 509 cases of cancer of the breast that have survived for over five years. Breast cancer in the male has a poor prognosis. Breast cancer in young women has no

TABLE IV

Multiple Carcinoma

1.	1931	Adenoca. Rectum	1941	Paget's of Breast (1951 L & W)
2.	1936	Ca. of Breast	1948	Ca. of Stomach
3.	1937	Ca. of Breast	1948	Papillary Cystadenoca. of Ovary
4.	1941	Ca. of Breast	1949	Epidermoid Ca. of Tongue

worse prognosis than in older women. Bilateral breast cancer has a poor prognosis, although not necessarily hopeless.

Stomach

Our tumor clinic has seen 113 cases of cancer of the stomach in the 17-year period 1932-48. Eleven and one-half percent (13) have lived for five or more years. These cases were all treated by sub-total gastrectomy.

Berkson[4] has reported on a statistical study of patients seen at the Mayo Clinic from 1940-49 and revealed that for every 100 patients examined, there were 80 laparotomies and 44 resections with 14 five-year survivals. At the Hines Veterans Hospital from 1931-47, for every 100 patients, there were 63 explorations and 32 resections, with four five-year survivals. The importance of early diagnosis and treatment cannot be over emphasized. Nevertheless, it is difficult to understand why some of our cases have survived for so long with only partial gastrectomy. It should be noted that our long-term survivals include seven cases who are living and well for seven to 14 years after surgery.

Three of the 13 cases died of metastases and one of cerebrovascular arteriosclerosis. Two others died of unknown cause, presumably due to metastases. Seven patients were living and well up to the last visit in the clinic, with three of them lost to follow-up after they had been observed for a number of years after operation.

TABLE V
Stomach

		Survival Time	*Status*
1.	1935	8 years	Dead — ASHD
2.	1935	7	Living — No follow-up since
3.	1939	14	Living & well
4.	1940	13	Dead
5.	1940	14	Living & well
6.	1943	5	Dead
7.	1942	9	Living & well No follow-up since
8.	1941	10	Dead
9.	1943	10	Living & well No follow-up
10.	1945	5	Dead
11.	1946	9	Living & well
12.	1947	7	Dead
13.	1947	7	Living & well

We have reviewed the histopathology of these cases and have confirmed the initial diagnosis of adenocarcinoma in each case. For the most part, these were well-differentiated adenocarcinomas. Four tumors were polypoid; one showed serosal involvement, but in general the longest-term survivors had polypoid or superficial lesions. It goes without saying that early or localized lesions have a better prognosis and at present this is one of the major endeavors in cancer education and treatment.

Lymph nodes were infrequently demonstrated so that one cannot evaluate the relationship between lymph node involvement and ultimate prognosis as evidenced by our long-term survivals.

The rarity of cancer of the stomach in young adults is borne out by our cases. We have only three cases out of 131 which were less than 40 years of age. Our long-term survivors were for the most part in the sixth and seventh decade.

Nine of our long-term survivors are female and four male. There is a general impression that the prognosis of gastric cancer is worse in females than in males. Our figures reveal the opposite to be true. Although they are small in number, they are significant according to the chi-square test.

In summary, we have 13 cases of cancer of the stomach surviving for 5 to 14 years after operation. This is 11.5 per cent of all cases. They were all treated by sub-total gastrectomy. The tumors were for the most part well differentiated. One-quarter of these were polypoid. These cases were in the older age groups.

Malignant Melanoma

We have reported on the cases of malignant melanoma[5] seen in the tumor clinic of the Rhode Island Hospital. Some features are worth-while repeating.

There are 47 cases in the files of the tumor clinic for the years 1932-48; 7 of these cases (14 per cent) have survived for 5 or more years. Many of these cases were terminal, or had an inadequate follow-up which had depressed the percentage of survival. The accompanying chart (Table VI) outlines the significant features of these cases. Five of the 7 cases had metastases which occurred within a year of treatment. These 5 cases have survived from 5 to 12 years, despite the appearance of metastases. To be sure, these are unusual occurrences but they do show that malignant melanomas are not invariably rapidly fatal diseases.

Some of these cases have had multiple skin metastases, as well as regional lymph node metastases, but life has been prolonged after regional lymph node excision, as well as of skin metastases.

In one of our cases, a 57-year-old white woman had a wide excision of a malignant melanoma of the foot. She had local recurrences in the next 2 successive years and these were excised. She was asymptomatic for 6 years until a lymph node metastasis appeared in the groin. This also was excised and she was then asymptomatic for 4 years, when she had a recurrence of tumor in the groin and expired 2 years later. Her total survival time was approximately 14 years. This case demon-

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TABLE VI
Malignant Melanomas

Case No.	Age	Sex	Interval before Metastas.	Survival after Metastas.	Total Period of Survival	Site	Remarks
1. 3996	57	F	11 mo.	10 yr. 10 mo.	11 yr. 8 mo.	Foot	Local excision; recurrences and lymph nodes excised 2, 9, & 12 yrs. later. Survived 14 yrs.
2. 4094	63	F			9 yr. 5 mo.	Foot	Local excision; no recurrences. Died of arteriosclerotic heart disease.
3. 5098	50	F			10 yrs.	Cvx.	Local excision; no metastases. Living and well.
4. 5590	46	M	8 mo.	7 yrs.	7 yr. 8 mo.	Chest	Local excision; multiple recurrences excised in next 2½ yr. Living and well.
5. 5733	25	F	4 mo.	5 yrs.	5 yr. 4 mo.	Foot	Local excision; multiple recurrences removed, but none when last seen in 1948.
6. 5975	52	F	First seen	6 yr. 5 mo.	6 yr. 5 mo.	Foot	Excision of metastatic node. No recurrences when last seen in 1949.
7. 8382	62	F	1 yr.	7 yr. 6 mo.	8 yr. 6 mo.	Foot	Leg amputation 6 yrs. previously for melanoma diagnosed elsewhere. Recurrence in stump.

strates the chronic nature of this disease and emphasizes that one should not take a nihilistic therapeutic viewpoint in the presence of metastases or recurrences.

In general, the degree of anaplasia of the tumor correlates somewhat with the ultimate outcome but it does not permit its use as a reliable prognostic aid.

Our long-term survivals are mostly in the middle-aged group. The majority of the tumors are on an extremity as contrasted, for example, with the face, with its rich blood supply and greater danger for metastases. The lesion on the cervix is unusual and its longevity is contrary to the usual experience.

These tumors were treated by wide local excision, without regional lymph node dissection. In general, lymph node dissection is recommended, but we have five cases who have lived for over 5 years without this procedure. These are obviously exceptional cases, since our figure of 14-per-cent long-term survival is not high.

Discussion

The causes for longevity with cancer are not clear. There are many factors cited by Harrington[1] which must be considered:

1. Adequacy of surgery.
2. Extent of malignant involvement at time of operation.
3. Location of the malignancy.
4. Degree of malignancy as partially shown by microscopic examination of the primary lesion.
5. Presence of other associated conditions such as pregnancy and lactation.
6. General constitutional diseases such as diabetes.
7. Age of the patient.

The most important factor is the extent of disease at the time of operation, as indicated by the presence or absence of regional lymph node metastases.

However, one cannot use this information in order to prognosticate in the individual case. Many of our long-term survivors would have originally been given poor prognoses because of the extent of their disease, general debility and the degree of undifferentiation of the tumor.

This would suggest that there must be other factors that may modify this disease. Some investigators believe that body tissues contain an inherent resistance to malignancy, which may be manifested by inhibiting the extension of the primary growth, as well as its metastases by a connective tissue reaction, such as fibrosis.

It has been suggested that there possibly may be an immunological reaction limiting the spread of disease.

One of the unexplained oddities of malignant tumors is, why they recur years after they have been initially removed and then suddenly grow wildly, spread throughout the body and lead to a rapid demise. One possibility is that there was a small focus of residual tumor, which had lain dormant and then had been stimulated to grow. Possibly this may be produced by hormones. Thus, in the treatment of metastatic or recurrent carcinoma of the breast, estrogens or testosterone, oophorectomy, adrenalectomy, or hypophysectomy have been used in an attempt to alter the steroids of the body and possibly modify the tumor under its influence. Conceivably, the glands of internal secretion may spontaneously influence the tumor, producing periods of growth and regression. This may apply in cancers of the breast and prostate and in malignant melanomas, since these tumors are be-

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THE BEGINNINGS OF MEDICAL EDUCATION IN RHODE ISLAND

Part II

SEEBERT J. GOLDOWSKY, M.D.

(*continued from September, 1955, volume XXXVIII, number 9, page 515*)

The Author. *Seebert J. Goldowsky, M.D., Surgeon, Miriam Hospital; Assistant Surgeon, Rhode Island Hospital, Providence, R. I.*

AT THIS POINT we shall take a brief look at the college and its surroundings. When the medical school was opened the only buildings on the campus were University Hall and President Messer's barn. The only structure added during the life of the school was Hope College, completed in 1822. "No other street but Angell [wrote a contemporary] then led directly to the river. What is now Waterman Street was chiefly a pasture for horses." The area between Thayer Street and the Seekonk River "consisted of unoccupied meadows and pastures." There was only a scattering of houses in the environs of the college. At the head of College Hill, on the site of the present Van Wickle Hall, the university built in 1810 at a cost of $1452 a brick building to house the grammar school which it had sponsored for many years. This was set aside as an anatomical building upon the opening of the medical school. Dr. C. W. Parsons described it as follows: "Its upper story was used for dissection, and the preparation of specimens for the lectures, and an opening or trapdoor allowed them to be lowered into the lecture-room beneath. The courses on anatomy appear to have been sometimes given . . . probably at an earlier period . . . in the upper rooms of Dr. Bowen's building at the corner of South Main and Leonard Streets. A certain anatomical tradition and aroma lingered around both these classic precincts. I think that most, if not all, the courses in other departments were delivered in University Hall. The audience frequently contained practicing physicians as well as pupils." In Reuben Guild's HISTORY OF BROWN UNIVERSITY (1867) the only reference to the medical school I have discovered has to do with this use of the building: "For many years after the completion of the building, the upper part was used for the Medical Lectures that were formerly given in connection with the College." Most students except those whose homes were in Providence lived at the college and board "never exceeded $1.40" per week.

The organization of the school is clearly described in the following circular issued about 1823 and now preserved in the John Hay Library collections:

"Medical Lectures in Brown University"

"The Medical Lectures in Brown University will commence in the Anatomical Building, in Providence, on the first Thursday in February, and be continued daily for nearly three months.

Theory and Practice of Physic and Obstetrics, by Dr. Wheaton	$10.00
Chemistry and Pharmacy, by Professor D'Wolf	10.00
Anatomy, Physiology and Surgery, by Dr. Parsons	15.00
	$35.00

"The public are informed that no pains have been spared to render the institution worthy of patronage. The Professor of Chemistry has, within the last year, made extensive additions to his apparatus, which render it very complete. A cabinet of minerals has been formed, and collections of specimens are making for teaching the other branches of natural history.

"The Anatomical Museum has recently received very important additions from various parts of Europe, and now contains every preparation, plate and instrument necessary to a teacher of anatomy. Students will be accommodated with separate sets of bones, and allowed ample opportunities in Practical Anatomy.

"A Medical Library is attached to the school, to which the students will be allowed full access.

"The lectures on Surgery will comprise about one fourth part of the course, and nearly every instrument now in use will be exhibited and described. When practicable, students will be allowed to attend surgical operations, and cases of sickness.

"Arrangements are made with the Steward of the College for boarding in the commons at $1.25 per week. Lodging rooms may be hired in the vicinity of the College at a moderate rent, which will make the price of board lower than at almost any Medical School in New England.

"The conditions on which Medical Degrees are conferred are the following:

continued on next page

1st That the candidate sustain a good moral character.

2 That he furnish the Professors with satisfactory evidence of his possessing a competent knowledge of the Latin language and Natural Philosophy.

3 That he shall have attended two full courses of lectures on Anatomy and Surgery, Chemistry and the Theory and Practice of Physic.

4 That he shall have studied three years (including the time of lectures) with physicians of approved reputation.

5 That he shall have submitted to a private examination held by the Professors during the last week of the lectures, or on the Monday and Tuesday preceding Commencement . . . and received their recommendation.

6 That he shall have written a dissertation on some medical subject and read and defended it in the College Chapel before the President, or such college officer as he may appoint, and the Medical Professors and such other professional or literary gentlemen as choose to attend. Where, however, the candidate can offer a satisfactory excuse for being absent at commencement, and has complied with all the other conditions, he will be allowed to send his dissertation, to be read publicly by some other person, all dissertations to be transmitted to one of the Professors at Providence, at least four weeks before Commencement, and read on the Monday and Tuesday preceding that day.

"Gentlemen wishing to become private pupils with Drs. Wheaton and Parsons are informed that they can be accommodated for one, two or three years; that Lectures will be given twice or thrice per week during the year, and that the use of a valuable Library will be allowed, with an extensive collection of Anatomical Preparations; . . . making the advantages for the elementary part of their education equal to those of any private establishment in the country. They have moreover made arrangements with the Professor of Natural Philosophy and the Professor of Botany, by which Medical Students will be allowed to attend their Lectures at the College."



Fig. 3. University Grammar School as it appeared about 1870. Anatomy lectures were held in this building during the active years of the Medical School. *(Courtesy of the John Hay Library, Brown University)*

In addition to the above there is a well-preserved copy of the catalogue of the school for the year 1822-23 and a photostat of another for the year 1821-22, the original of which is in the Harvard University Library.

University Medical Association

During most of the life of the medical school there existed a Brown University Medical Association organized for the benefit of professors, students and other interested physicians. The constitution, bylaws and minutes in the original manuscript are also in possession of the John Hay Library, clearly written and in a beautiful state of preservation. The preamble to the constitution reads as follows:

"As every attempt to advance science or diffuse knowledge in general, must be esteemed meritorious, by the intelligent and good: as the medical art not only affords an extensive field for the cultivation of the philosophic and inquisitive mind, but is entirely calculated to ameliorate the affections and miseries incident to human life, and administer comfort and ease to mankind, and as literary associations by giving an opportunity, for an interchange of opinion and a resciprocity [*sic*] of sentiments, conduce to an end so desirable and laudable, we the undersigned do agree to form ourselves into an association or literary community under the name and title of the Brown University Medical Association and do, for the regulations and governments thereof unanimously agree to adopt the following constitution . . . ."

The association first met on November 9, 1811, and adopted its constitution two days later. Weekly meetings were held during the academic year. The association conducted a library and at its initial meeting authorized the purchase of books. Interest in this activity was maintained until the end. Medical discussions were typically in the form of debates, participants analyzing the pros and cons of some stated proposition. Typical examples are the first and the very last recorded subjects: "Whether any diseases were produced by absorption" and "In which country France or England has the Medical Science attained the highest degree of eminence." Following its organization the association met regularly until September 4, 1816, on which date it adjourned sine die. No further meetings were held

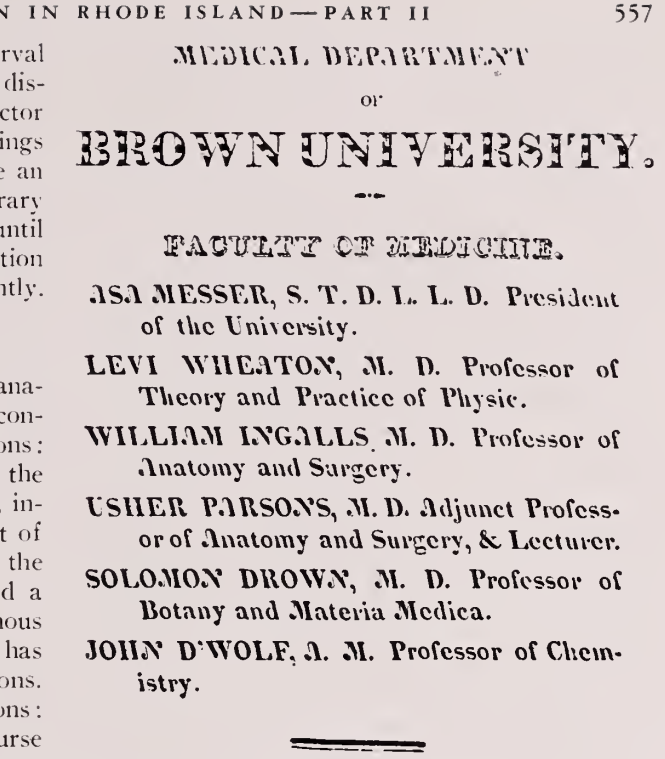
or recorded for the next seven years. This interval corresponds roughly with the period of relative disorganization extending from the death of Doctor Eddy to the accession of Doctor Parsons. Meetings were resumed on May 9, 1823, at which time an audit of the treasury and an inventory of the library were ordered. They were held regularly until March 28, 1825, on which date the organization appears to have gone out of existence permanently.

Anatomical Study Problems

The problem of procuring specimens for anatomical study presented, as previously noted, continuing difficulties. Wrote Doctor C. W. Parsons: "The whole matter of supply of material for the practical study of anatomy was, as it must be, involved in difficulty and hazard. A full account of it would include tales of nocturnal adventure, the evasion or befooling of night watchmen, and a mysterious traffic." A rather famous or infamous episode concerning this cadaverous materiel has been told and retold in slightly differing versions. According to the account of Doctor C. W. Parsons: "A story is told of a certain skeleton in the course of preparation, which was left in a barrel in front of the 'anatomical building.' . . . By some forgetfulness, it was allowed to remain out-of-doors till college students began to roll and kick it down the steep of College Street, and at the level of Benefit Street it ran against some obstacle, I think the steps of the old town house. Out came the head of the barrel, followed by another head, and great was the consternation and excitement. A startled crowd gathered around the spot; stories were soon astir of desecrated graves; search was even made in one place of a recent burial, which was found not to have been disturbed. A medical student, who was supposed to be implicated, found it convenient to visit his uncle's house in the country, and remained there till the affair had blown over. Dr. Parsons . . . claimed the bones as his own property, but public opinion demanded a prompt and decent burial." It was a matter of tradition in later years that the unpleasant notoriety produced by this unsavory splattering of "armless trunks and trunkless heads" had much to do with attracting public attention to the rumored lack of discipline among the students and the eventual extinction of the school.

Faculty Salaries

The matter of adequate and regular salaries for the faculty was, as we have noted, a course of chronic dissatisfaction. There is in the John Hay Library the original of an interesting letter directed by Doctor Solomon Drowne to the "Honorable Corporation of Brown University" in the year 1824. He addressed himself in this way: "I am not accustomed to speak in my own behalf:—permit



MEDICAL DEPARTMENT

OF

BROWN UNIVERSITY.

FACULTY OF MEDICINE.

ASA MESSER, S. T. D. L. L. D. President of the University.

LEVI WHEATON, M. D. Professor of Theory and Practice of Physic.

WILLIAM INGALLS, M. D. Professor of Anatomy and Surgery.

USHER PARSONS, M. D. Adjunct Professor of Anatomy and Surgery, & Lecturer.

SOLOMON DROWN, M. D. Professor of Botany and Materia Medica.

JOHN D'WOLF, A. M. Professor of Chemistry.

PROVIDENCE, R. I.

December—1822.

B. FIELD, PRINTER.

Fig. 5. Page from catalogue of the Medical Department of Brown University for academic year 1822-23, showing medical faculty for that year. ***(Courtesy of the John Hay Library, Brown University)***

me, then, without further preamble, to enter on the subject of my memorial." Belying this protestation of brevity there followed a long and involved discourse on the beauties and satisfactions of the study of botany and nature. "But to come to the pith of the business [he then continued]:—what I wish is, such a compensation as Professor in the University and curator of our little garden, that I need not be obliged to look to the students for pay,—a troublesome task, attended with lapses. I do not ask for a salary of so high amount as the Professors of Chemistry and Oratory receive,—$500 and $600 respectively though they are my juniors,—for I was one of the very first to introduce actual lecturing in the University,—Professor Nuthall receives $500 annually merely as Curator of the Garden at Cambridge;—a very pleasant business. The mentioning this, however, can avail me but little as our garden is not Cambridge garden,—yet it is the germ and nursery of a botanic garden, that may with patronage increase. It was got up and has been supported hitherto without any expense to the College. I have exercised in it considerably, in introducing plants, useful in Medicine, Rural Economy, and the Arts.—But apart from its utility in these respects, it may be considered as a

continued on next page

Morrill Kinman

CIRCULAR.

Medical Lectures in Brown University.

THE Medical Lectures in Brown University will commence in the Anatomical Building, in Providence, on the first Thursday in February, and be continued daily for nearly three months.

Theory and Practice of Physic and Obstetrics, by Dr. WHEATON, - - -	$ 10 00
Chemistry and Pharmacy, by Professor. D'WOLF, - - - - - - - - - -	10 00
Anatomy, Physiology and Surgery, by Dr. PARSONS, - - - - - - - - -	15 00
	$ 35 00

Fig. 4. Front page of Circular appearing in 1822, announcing Medical Lectures in Brown University. *(Courtesy of the John Hay Library, Brown University)*

leaf of a beautiful volume of nature, in which one may read much of the goodness and wisdom of the Being, whose power is adequate to the production of everything. [signd] Solomon Drowne." Although it is not definitely known whether this letter had any positive influence with the trustees, it is a matter of record that his allowance from fees which had been only $100 in 1823 was raised to $250 in 1825.

Medical Journal Reports

There appeared in Volume II of the BOSTON MEDICAL INTELLIGENCER covering the years 1824 and 1825 a number of references to Brown Medical School and the state of affairs in Rhode Island, of which the discourse by Doctor Waterhouse above referred to appears but to have been a part. An anonymous correspondent wrote: "Its local situation enables us to account for the fact, that the Medical School of Brown University has never had a very great reputation abroad,—for it is between the Massachusetts Medical College on the north, the New York College of Physicians and Surgeons on the south, and the Berkshire Medical Institution on the west, and to these three neighboring schools many of their pupils resort. The course of public lectures in their Medical School is by no means inferior to any in their neighborhood, in point of accuracy or splendor. . . . We had the pleasure of being invited into Professor Parsons' lecture room. . . . His Italian models of anatomy are done in a superior style. . . . [One] could not but admire his unceasing labour to benefit the class, by his anatomical knowledge, as well as practical experience. We had not the satisfaction of listening to the other professors . . . but . . . we learn that their abilities as teachers are uncommonly great."

6

Officers of Instruction.

REV. FRANCIS WAYLAND, JUN. D. D.
President.

*SOLOMON DROWN, M. D. *Professor of Materia Medica and Botany.*

*HON. TRISTAM BURGES, LL. D. *Professor of Oratory and Belles Lettres.*

*LEVI WHEATON, M. D. *Professor of the Theory and Practice of Physic.*

*JOHN D'WOLF, A. M. *Professor of Chemistry.*

*USHER PARSONS, M. D. *Professor of Anatomy and Surgery.*

*HORATIO GATES BOWEN, A. M. *Professor of Natural History, Librarian, and Keeper of the Cabinet.*

WILLIAM G. GODDARD, A. M. *Professor of Moral Philosophy and Metaphysics.*

REV. ROMEO ELTON, A. M. *Professor of Languages.*

REV. ALEXIS CASWELL, A. M. *Professor of Mathematics and Natural Philosophy.*

JOHN WAYLAND, A. B. *Tutor.*

JOHN H. WEEDEN, A. B. *Tutor.*

REGISTER AND STEWARD.
LEMUEL H. ELLIOT.

*The gentlemen to whose names the asterisk is prefixed, are not of the immediate government; and do not, at present, give any instruction in the University. The duties of Professor of Oratory and Belles Lettres, are performed by the President and the Professor of Moral Philosophy—and the duties of Professor of Chemistry, by the Professor of Natural Philosophy

Fig. 6. Roster of Officers of Instruction in Brown University catalogue for the year 1828-29, showing asterisks before names of medical professors and accompanying footnote as described in text. *(Courtesy of the John Hay Library, Brown University)*

He felt constrained to add, however, "We scarcely recollect a medical publication which has ever emanated from Rhode-Island. The physicians there have neither a periodical journal, nor in fact, leisure to publish, even if they possessed [such] a medium. . . . Surgery, although well managed . . . has never had any very distinguished or able masters. . . . It is said . . . that the celebrated Dr. Miller, of Franklin, Mass., does a third part of the chirurgical business of Rhode Island." Wrote another correspondent: "The plan of the School was, at present, better, but yet it is susceptible of much improvement. I can by an analysis, [which he proceeds to give] give you some idea of this school which, I add, and without ostentation, might, and ought to stand pre-eminent, from the character and talent concentrated in many of its professors, though its number of students will ever be limited . . . from its location in the immediate vicinity of the flourishing schools of Boston and New York." Wrote the editor in comment: "It must be that something is 'rotten in Denmark'. . . ." Following a letter in defense of the school the editor finally published the following note: "We have received several letters alternately praising and blaming the medical school of Brown University; . . . as the complainant . . . keeps his name behind the curtain, we now positively assure him that his communications will receive no further attention unless he is willing to overcome his hesitation in signing his name." Thus came to an end this rather strange correspondence.

Several other items appear in this volume of the Boston Medical Intelligencer which have bearing on the then current activities of the profession in Rhode Island. Among these is the following: "The library of Brown University has received from two young gentlemen alumni, who are now in Europe, a respectable donation of French books, among which are valuable works on Natural History, and on Anatomy and Surgery. The anatomical plates of Cloquet, consisting of 240 engravings of folio size, are executed in a very superior style. These gentlemen have also forwarded valuable additions to the chemical and philosophical apparatus, already belonging to the University."

Farther on we read: "Dr. Usher Parsons, Professor of Surgery in Brown University, has recently established an infirmary, in Providence, for diseases of the eye." Also: "A hospital and quarantine establishment are in contemplation at Providence, R. I., and a lot on Fields Point has been selected and purchased for its location." The problem of hospitals will receive brief attention later.

Medical Library Beginnings

An account of the annual meeting of the Rhode Island Medical Society for 1824 appearing in the same volume is also of interest: "The Society received a letter from Dr. Caleb Fiske, tendering his resignation as a Fellow of the Society, in consequence of ill health, and accompanied by a donation of 72 volumes of valuable books . . . intimating, also, his intention to provide a fund, the annual income of which is intended to excite competition in the investigation of such medical subjects, as the Society may propose for discussion." Dr. Fiske actually lived on another ten years, and the first Fiske prizes were not awarded until 1835. It was noted in the same minutes that Doctors Levi Wheaton and Solomon Drowne were to be appointed orators for the next "anniversary" meeting.

The letter of presentation accompanying Doctor Fiske's gift of medical books is in itself a document of considerable discernment. He wrote: "Believing it to be an object of considerable interest, to establish a Medical Library for the use of the Society, and as no successful effort hath hitherto been made to effect so desirable a purpose, I am induced to commence the work by presenting to the Society seventy-two volumes (including numerous instructive plates). This small beginning may serve as a nucleus for the accretion of useful matter, and it is to be hoped will be followed with additions from time to time by the Society or some of its members. Such an establishment, by furnishing the means of intellectual improvement will probably excite a propensity for medical reading and research, and lead to results honorable to the Society and beneficial to the Community." His hopes of founding a medical library, however, were not then realized. Some years later the following was reported to the Society: "His gift received few, if any additions. The books became obsolete, superseded by more modern works, and were finally donated to the Rhode Island Hospital, in 1868." The Medical Society which was founded in 1812 and of which he became president in 1823, was another and contemporaneous manifestation of the same intellectual ferment which led to the establishment of the medical school. Many of the same personalities were involved in both movements. Amos Throop was the first president of the Rhode Island Medical Society and died in office. An important activity of the Society during these early years, in the face of inadequate regulation and licensure, was the examination and certification by its board of censors of the local practitioners of medicine. Doctor Fiske, himself a pupil of Doctor William Bowen and a successful preceptor in his own right, was granted an honorary M.D. by Brown in 1812.

Medical School Terminated

The medical school came to a rather abrupt end during the years 1827 and 1828 and in a rather odd way. At a special meeting of the corporation held

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on December 13, 1826, the resignation of President Asa Messer, which had been submitted earlier, was accepted and the Reverend Francis Wayland, Jr., of Boston was unanimously selected to be his successor. On the state of the college at this time Reuben Guild wrote: "The circumstances in which he found the College were by no means favorable. . . . The last two or three years of Dr. Messer's administration had been marked by idleness and dissipation on the part of the students. Influences beyond the reach of the President rendered salutary discipline almost impossible, and the results were disastrous alike to the moral and intellectual character of the men under his care." This view of the situation appears to be the conventional one, as Professor Bronson writes: "President Wayland's first work was to tighten the reins of moral and mental discipline which in the last few years had been somewhat relaxed." The tradition persisted, however, as we have already noted, that there was a more than casual relationship between the affair of the barrel of bones and the peculiar severity with which the impending blows were to fall upon the medical school.

Be that as it may, Dr. Wayland "brought with him [stated Dr. C. W. Parsons] very definite views as to college discipline, and a profound conviction of its importance." In pursuance of his objectives he revived and extended an old rule which had required the instructors to visit the students' rooms.

At a special meeting of the Corporation held in March of 1827 the following resolution, in all probability inspired by the President, was adopted:

"*WHEREAS*, it is deemed essential to an efficient course of instruction, and to the administration of discipline in this University, that all its officers be actual residents within the walls of the Colleges; therefore,

"*RESOLVED*, That no salary or other compensation be paid to any Professor, Tutor or other officer, who shall not during the course of each and every term occupy a room in one of the colleges (to be designated by the President), and assiduously devote himself to the preservation of order and the instruction of the students, or the performance of such other duty as may belong to his station."

The secretary was directed to send copies to the non-resident professors. This action was implemented at the next regular meeting in the following manner. Salaries of present and future faculty members were approved only on condition that they "devote themselves during term-time exclusively to the instruction and discipline of this institution, occupy rooms in college during study hours, and attend in their several departments such recitations as the President may direct, not exceeding three recitations of one hour each in every day."

The names of the members of the medical faculty (Doctors Browne, Wheaton, DeWolf and Parsons) appeared as usual in the University catalogue of 1827-28. The ensuing five years, however, produced a significant series of changes. The catalogue of 1828-29 presented the full medical faculty, but to each of the names was affixed an asterisk with the following explanatory footnote: "The gentlemen to whose names the asterisk is prefixed, are not of the immediate government; and do not, at present, give any instruction in the University." In the following year the same device was used, but in the meantime Dr. Levi Wheaton had eliminated himself. The catalogue for the academic year 1830-31 contained the somewhat more definitive statement: "The gentlemen to whose names the asterisk is prefixed, give no instruction in the University, and have no concern in its government." Doctor Usher Parsons dropped out in 1831-32, leaving only Doctors Browne and DeWolf. A curious variation can be noted in the catalogue of that year in that the words "for the present" were appended to the footnote. An anonymous hand apparently deeming this phrase too tentative, had struck it out with pen and ink, leaving the final wording unchanged from that of the previous year. By the time the catalogue of 1832-33 appeared the medical faculty had been liquidated quite completely.

Underlying Motives Reviewed

The motives of President Wayland in thus sacrificing the medical school are not now entirely clear. He himself had studied medicine for three years following his graduation from Union College, both with preceptors in Troy, New York, and by attending lectures in New York City. Professor C. W. Parsons was of the opinion that he had no hostile feeling toward the school. The view was expressed in later years (1859) "that the proximity of medical schools in Boston, New Haven and Pittsfield, which were provided with ample accommodations, would always prevent the growth and success of one in Rhode Island and the school was therefore abandoned in 1826 [*sic*]." There is no contemporary document which supports this concept, but it may nevertheless be of some significance as it was written by Doctor Usher Parsons.

The weight of evidence and opinion, however, favors the view that the destruction of this promising institution was in fact merely incidental to otherwise successful and praiseworthy academic reforms. President Wayland himself provided a sturdy example for the moral and intellectual austerity which he sought to impose upon students and faculty alike. He doubtless knew what effect these measures would have upon the medical professors

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NEW ENGLAND AND THE AMA

THE THIRD annual meeting of the American Medical Association was held in Boston in 1849. Three times subsequently, the last in 1921, the scientific session came to Boston, and in the intervening years also met at New Haven (1860) and in Newport, Rhode Island (1889).

As the Association grew in size it found that there were few cities in the nation able to accommodate the number of physicians and their families, and the allied organizations, desirous of participating in the world's greatest medical conclave. As a result it is now thirty-four years since the AMA has come to the Northeast.

The long due visit will be made this year—to Boston on November 29 through December 2. But it will not be Boston's meeting, for the Bay State physicians have graciously waived the privilege of being the single hosts to the doctors of America, and have organized the Interim Clinical Session as a New England presentation. This is fitting, for we are not only a compact region where our states have long since learned to work in close harmony, but more particularly physicians from New England contributed in great measure to the development of the American Medical Association through its 110 years of existence.

New England had two medical schools, Harvard and Dartmouth, long before physicians considered formal organization of their own groups, and the establishment of standards for medical education. The Boston Medical Society had been started about 1735, and New Haven County had an organization, while on the state level Massachusetts, New Hampshire and Connecticut were already chartered medical societies, and in 1848, a year after the start of the AMA, the Rhode Island Medical Society was organized.

When the American Medical Association was formally started Doctor Luther Ticknor, then president of the Medical Society of Connecticut, was one of the prime organizers with Doctor Nathan Smith Davis of Binghamton, New York. Later when the first board of trustees was created it included a Doctor Alonzo Garcelon of Maine who later became president of the trustees when the Association was incorporated. In 1853 Doctor Usher Parsons of Rhode Island was first vice president of the Association.

Through the years New England has had nine of its residents named to the presidency of the AMA, with seven of the physicians claiming Boston as their home, and two, New Haven. The most

continued on next page

recent Bostonian to head this honor to New England was Doctor Roger I. Lee who was the 99th president, serving in 1945.

The third annual session, held in Boston in 1849, saw Doctor John Collins Warren, who three years before in the amphitheater of the Massachusetts General Hospital had done the first public operation under ether anesthesia, nominated as president for the ensuing year. At that meeting standing committees to undertake measurements of progress in each important medical field were established, and preliminary steps taken toward the high standard that was ultimately to prevail in the advancement of American medicine through plans to elevate the standard of medical education.

Sixteen years later the convention again assembled in Boston, and at that session a resolution was adopted to establish norms for the publication of scientific papers that have been instrumental in making the quality of the medical literature of the United States the world's finest.

Rhode Island had the honor of entertaining the American Medical Association at Newport in 1889, and our Doctor Norman MacLeod, health commissioner of that city, still treasures a copy of the interesting program of that occasion, which of course included for the visitors a Rhode Island clambake.

The Newport meeting was marked by many interesting features. Doctor William Pepper gave the address on medicine and devoted it to the life of Benjamin Rush; the Board of Trustees reported that the JOURNAL OF THE AMA had become well established and was a credit to the Association, increasing its page content from 32 to 36 weekly (the average JOURNAL now has 180 pages weekly); a resolution was adopted on the suggestion of the American Social Science Association that a more thorough general education prior to the study of medicine be encouraged; and it was voted to send representatives to the meeting of the U. S. Pharmacopoeia Convention.

The year the first AMA directory of physicians was published, 1906, saw the meeting again at the hub city of the Massachusetts Commonwealth. This was the time the Council on Pharmacy requested that it be supplied a laboratory at the headquarters office; $5,000 was appropriated to the California fund for the benefit of physicians who suffered by the earthquake and fire; for the first time the Council on Medical Education recommended a year of college education before entrance into a medical school; the scientific exhibit completed its seventh showing; and the battle against proprietary medicines assumed strong proportions.

It is interesting to note, and we know not whether there is a family connection, that when the AMA met in Boston in 1921, its last previous visit to this area, the speaker of the House of Delegates was Doctor Dwight Henderson Murray of Syracuse, N. Y., and this December, Doctor Dwight Harrison Murray of Napa, California, will be seated on the rostrum as president-elect of the Association. We will construe this is a very bright omen, for the 1921 Boston session was a lively and successful one.

The Interim Meeting, started several years ago, has not attracted as large an attendance as the annual session held in early June. But the clinical presentations are equally good, the scientific and technical exhibits on a par with those presented at the annual get-together, and the work of the House of Delegates as important as always.

In 1921 the registered attendance at the annual meeting in Boston was 5,506. We are certain that the Interim Clinical Session on November 29-December 2 will far top that figure. The opportunity to hold such an important convention in New England should be welcomed by every physician. Certainly no Rhode Island doctor would appear to have much excuse for not making the 45-mile trip to our neighboring state's capitol sometime during the meeting week.

Welcome to New England, AMA! We are proud to be hosts again to the greatest medical organization the world has ever seen.

HOSPITAL DIRECTORS

We wish to call your attention to the letter in this issue from a prominent psychiatrist discussing some aspects of the recent sad upheaval at Butler Hospital. Of course, what is discussed in this letter goes far beyond one hospital. These matters are attracting a good deal of attention nowadays. At the recent meeting of the New England Surgical Society there was a panel discussion on *Hospital Administration and the Doctor*. This was participated in by two surgeons from two of the biggest, highest grade hospitals in the country, a director or superintendent (we are not sure of his title) of one of these hospitals, and another, not a physician, who is on the board of directors at one of the best-known clinics in the country. These four constituted a remarkable team. It was interesting that the nonmedical member brought up the subject of physicians on the boards of hospital directors and approved of that.

We feel that there is little doubt that the professional staff of hospitals have often been considered merely as technicians on even a higher plane than the most artistic and skillful designers or fabricators in industrial life. We are afraid this impression goes back to the days of the Barber-Surgeons and that it is perhaps more deeply rooted in New England.

There are, however, a great many hospitals in this country that do have physicians on their boards.

There are tremendous problems involved in hospital management in which it would not be reasonable to expect the advice of a physician to be particularly valuable; nevertheless, we feel that the great object for which hospitals are maintained is the medical care, and we do not believe that businessmen, in fact any other type of man, except a physician is well qualified to pass on these problems. Some hospitals which have not allowed physicians to reach this exalted station call attention to the fact that they have combinued committees of the trustees and doctors who take up all the important problems. This sounds well, but the initiative always comes from the trustees and it may well be that in the multiplicity of problems that arise, occasionally the importance of some of them do not impress the trustees sufficiently.

We also have a strong feeling that in these days fashion is playing altogether too great a part in design. We are not sure but that design is sometimes more important nowadays in buildings than it is in women's attire. Although the majority perhaps of new hospitals, which after all have some of the attributes of manufacturing plants, are being built as skyscrapers, we have been interested in riding through the country to find that even now many manufacturing plants are being kept as close to the ground as an up-to-date motel. We think that hospitals should move very slowly in abandoning expensive buildings, undoubtedly better constructed than the new ones, which sad experience tells us are very apt to have a good deal of "Jerry-building" in them.

THE DR. J. E. MOWRY FUND

Members who date back very far in the Providence Medical Association will well remember a tremendous great figure of a man with large, rugged features and a voice as deep and booming as any foghorn, who was accustomed to sitting in the front row at practically all our meetings. When new members came up for election, he would rise to his great height and say, "Mr. President, I move you sir that the by-laws be suspended and the secretary instructed to cast one ballot for the election of these members."

This was Doctor Jesse E. Mowry, who at one time or another held practically all the offices in the Providence Medical Association and the State Society, including the presidency of the Providence Medical Association. In the last part of his active career with us he was treasurer of the State Society and he was indeed a watchdog of the treasury. Few men have rendered such service to the medical profession in this state as did Doctor Mowry.

He was a general practitioner. As far as we know he was not connected with the staff of any of our hospitals, but throughout his career he maintained a familiarity with all the advances in medicine. No man was ever more respected or admired by a large group of patients. When he died on May 3, 1952, he left a widow who had to be kept in one of our institutions. This necessitated, of course, a large expense and he provided that the expense should be met from his estate, and that when the widow died a certain portion of the residue should come to the Rhode Island Medical Society. We are pleased to state that we have just received the goodly sum of $6,131.54. Doctor Mowry appreciated how awkward it sometimes was to have too many restrictions on such a bequest; he did not intend that this should happen as far as he was concerned, and he left this entire sum to be invested and income to be used for our current expenses.

We have never had anybody just like Doctor Mowry, but we wish we had.

THE GREAT FLOOD

About a dozen years ago, the City of Hartford, fearing that their big industrial plants might be bombed, organized a defense program. The man responsible for the medical end of this was the late Doctor Donald Wells. The bombers never came over, but the big top of the Ringling Brothers Circus caught on fire. Many people died and even more people were severely burned. The defense organization rose to the occasion and the story they had to tell us when we went down to the Hartford Hospital to see how things were handled was truly an inspiring one. Now in Rhode Island Governor Roberts has had organized a civil defense program, and under the leadership of the late General Murphy, and since his death, of Colonel, now General McGreevy, a most elaborate system of preparations has been put into effect.

continued on next page

RE BUTLER HOSPITAL EDITORIAL

September 15, 1955

Editor-in-Chief
Rhode Island Medical Journal:

The editorial which appeared in the last issue of the RHODE ISLAND MEDICAL JOURNAL regarding Butler Hospital was excellent. I greatly appreciated reading it, and feel that it represented correctly the situation as it exists.

I was particularly interested in your remarks regarding the broader base for a Board of Directors. I think this is a very good suggestion, and if followed out we would still have the hospital.

Your reference to the present facility is also very good, as certainly institutions are made up of people, and not buildings.

I wanted you to know that I very much enjoyed this article, and hence this letter.

Sincerely yours,

FULLER MEMORIAL SANITARIUM
LAURENCE A. SENSEMAN, M.D.
Medical Director

Once again we looked for bombers, but we got water from the skies. All the elaborate preparations paid off by what has been accomplished for relief in the northern part of our state. We have before us a report of the welfare services in the Woonsocket Flood written by Mr. Edward F. McGrath, Co-ordinator of Emergency Welfare. Under the leadership of General McGreevy, Mr. McGrath has been living at the scene of disaster. Previous experience let us know that he would be on the job working not only tirelessly, but also efficiently.

The story starts at 9:30 A.M., August 19, 1955, when General McGreevy and Mr. McGrath went to Woonsocket and were joined by Mayor Coleman and Chief of Police Edgar C. Turcotte. At that time there was a great deal of damage already done, but they were able to look it over and size up the situation; within a few hours it was evident that those who wished to survive would have to leave the low areas and take to the heights. Evidently there was lots of willing help from the doctors, nurses, Red Cross, the Salvation Army and even the local restaurants. One interesting item was: "One Clergyman provided Clam Chowder and Fish and Chips for Auxiliary Policemen."

One of the incongruous features of such floods as these is that there is a lack of drinking water. Mains are ruptured and have to be shut off, if possible, and certainly the flooding waters are not fit to drink. The primitive conditions that such a disaster produces is emphasized by the fact that the drinking water had to be brought in by tanks provided by the National Guard and the Narragansett Racing Association. Mr. Reidy's Department of Social Welfare had to man shelters for twenty-four hours a day for seven days to assist the Red Cross.

The medical work necessary was under the direction of Doctor Deery and his staff of nurses, and at the last reports which we had they were still right there. One happy observation which we can make right here is that the efficient handling of all these terrific problems makes the task of the medical profession easier. We have heard no suggestion that typhoid, dysentery, or the other infections associated in past years with catastrophes, have been at all prominent at this time. However, only eternal vigilance on the part of the Health Department will prevent serious medical dangers rising. We may well be proud of the way in which this disaster has been handled by General McGreevy, Mr. McGrath and all their willing assistants.

LONG-TERM SURVIVAL IN CANCER OF BREAST, STOMACH, AND IN MALIGNANT MELANOMAS

concluded from page 554

lieved to be under hormonal (steroid) influence.

The statistics cited should serve as a base line of prognosis based on experience in the local medical community. The figures are for a group of the more unfavorable cases. Nevertheless, they show that even in these cases, cancer is not invariably fatal. It should be emphasized that cancer is a chronic disease. Thus, in Daland's[2] analysis of 100 consecutively untreated patients with breast cancer, *22* per cent were alive at the end of five years and nine per cent at the end of seven years. Although cancer is frequently a cause of death, it may not occur for many years. The doctor should keep this in mind when offering a prognosis about tumor to a patient or family.

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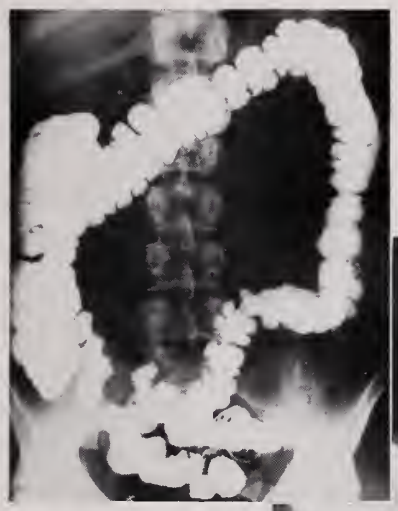
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October 1, 1955

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Telephone numbers have been checked with the latest available directories and every effort has been made to insure accuracy.

Any errors in this listing should be reported immediately to the Executive Office of the Society.

*Indicates non-resident member.

KEY TO SPECIALTIES

A—Allergy
ALR—Otology, Laryngology, Rhinology
Anes—Anesthesiology
Bact—Bacteriology
C—Cardiovascular Disease
CP—Clinical Pathology
D—Dermatology
G—Gynecology
GE—Gastroenterology
Ger—Geriatrics
HAd—Hospital Administration
I—Internal Medicine
Ind—Industrial Practice
N—Neurology
NS—Neurological Surgery
OALR—Ophthalmology, Otology, Laryngology, Rhinology
Ob—Obstetrics
ObG—Obstetrics, Gynecology
Oph—Ophthalmology
Or—Orthopedic Surgery
P—Psychiatry
Path—Pathology
Pd—Pediatrics
PH—Public Health
PL—Plastic Surgery
PM—Physical Medicine
PN—Psychiatry, Neurology
Pr—Proctology
Prev. Med—Preventive Medicine
Pul—Pulmonary Diseases
R—Roentgenology, Radiology
S—Surgery
U—Urology

Information compiled from the American Medical Association Directory, the Directory of Medical Specialists and the Yearbook of the American College of Surgeons.

The name of a physician who *limits his practice* to one field is marked with the appropriate symbol.

A

Abbate, Rocco (*Kent*) 873 Warwick Avenue, Lakewood (I) HO 1-3323
Abramson, Lewis, (*Newport*) 280 Broadway, Newport (Pd) Newport 5400
Addario, Carmelo, (*Washington*) Box 323, North Road, Shannock Carolina 4-7213
Addonizio, Ercole A., 928 Manton Avenue, Providence EL 1-8112
Adelman, Maurice, 209 Angell Street, Providence 6 (Pd) DE 1-9129
Adelson, Samuel, (*Newport*) 135 Touro Street, Newport (S) Newport 784
Agnelli, Freeman B., (*Washington*) 29 Elm Street, Westerly (PH) Westerly 2507
Allen, Reginald A., 289 Angell Street, Providence 6 (Pd) GA 1-5552
Allin, Francis E., 11 George Street, North Providence CE 1-6411
Anderson, Carl V., (*Kent*) 584 Cowessett Road, Warwick (S) TU 4-4262
Angelone, C. Thomas, 872 Park Avenue, Cranston 10 HO 1-3900
Angeloni, Tito, 151 Jastram Street, Providence
Appleton, Ruth, 41 Taber Avenue, Providence 6 (Pd) GA 1-4033
Archetto, Angelo, 964 Cranston Street, Cranston (Anes) EL 1-3717
Arciero, Michael, 225 Admiral Street, Providence 8 GA 1-7330
Arlen, Richard S., 359 Broad Street, Providence 7 DE 1-8210
Armington, Herbert H., 789 Broad Street, Providence 7 ST 1-4115
Ashton, George W., (*Woonsocket*) Chapel Street, Harrisville Pascoag 91
Ashworth, Charles J., 184 Angell Street, Providence 6 (S) GA 1-4370
*Astle, Christopher J., 1232 East 27th Place, Tulsa, Oklahoma (Oph)
Ayala, Alfredo, Capt., MC (*Kent*) U. S. Army Hospital, 8454th DU, Sandia Base, Albuquerque, New Mexico

B

Babcock, Henry H., 71 Rutledge Road, Belmont, Massachusetts (P)
Badway, Joseph M., 549 Broadway, Providence 9 UN 1-3947
Baldridge, Robert R., 192 Angell Street, Providence 6 (S) GA 1-3448
*Bandeian, Alice M., (*Pawtucket*) 210 Pine Street, Holyoke, Massachusetts Holyoke 2-3254
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continued on page 568

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*Barry, Ambrose G., (*Pawtucket*) Veterans Administration Hospital, Sunmount, New York
Bartley, James H., Jr., 7 Benefit Street, Providence 3 DE 1-6350
Basilevich, Ivan, State Hospital for Mental Diseases, Howard (Ger) HO 3-8100
Batchelder, Philip, 129 Waterman Street, Providence 6 (R) GA 1-2166
Bates, Reuben C., 122 Waterman Street, Providence 6 (Pd) GA 1-4233
Baute, Joseph A., (*Kent*) 4547 Post Road, Warwick TU 4-9440
Beardsley, J. Murray, 154 Waterman Street, Providence 6 (S) UN 1-1880
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Beaudoin, Louis I., (*Pawtucket*) 796 Central Avenue, Pawtucket PA 2-7696
Beaudreault, Elphege A., (*Woonsocket*) 441 South Main St., Woonsocket (S) Woon. 4949
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Beckett, Francis H., 189 Waterman Street, Providence 6 GA 1-3342
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Blackmore, Paul A., 141 Waterman Street, Providence 6 GA 1-7487
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Boucher, Reginald H., (*Pawtucket*) 704 Main Street, Pawtucket PA 3-5534
Bourn, Lucy E., 456 Brook Street, Providence 6 (Pd) DE 1-1694
Bowen, Earl A., 669 Park Avenue, Cranston 10 HO 1-4130
Bowen, J. Robert, 205 Waterman Street, Providence 6 (S) JA 1-0500
Bowles, George E., 154 Waterman Street, Providence 6 (ObG) DE 1-1898
Boyd, James F., 195 Angell Street, Providence 6 (R) GA 1-1589
Bradshaw, Arthur B., 49 Beacon Avenue, Providence 3 GA 1-3852
Bray, Russell S., 454 Angell Street, Providence 6 (GE) PL 1-2440
Brennen, Earle H., 58 John Street, East Providence 14 EA 1-0942
Breslin, Kate, 48 Dartmouth Avenue, Warwick WI 1-1519
Breslin, Robert H., 1494 Broad Street, Providence 5 HO 1-3113
Brochu, Charles E., (*Woonsocket*) 38 Hamlet Avenue, Woonsocket (R) Woonsocket 6174
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Brownell, Henry W., (*Newport*) 278 Broadway, Newport Newport 512-W
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Bruno, Louis C., 915 Smith Street, Providence (ObG) DE 1-3722
Bruno, Rocco, (*Pawtucket*) 193 East Avenue, Pawtucket PA 3-4669
Bryan, Charles E., 425 Willett Avenue, Riverside 15 EA 1-0961
Buffum, William P., 122 Waterman Street, Providence 6 (A) GA 1-3446
Burgess, Alex M., 107 Bowen Street, Providence (I) DE 1-8454
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Burrows, Ernest A., 116 Waterman Street, Providence 6 (PN) GA 1-3636
Burton, Kenneth G., 124 Waterman Street, Providence 6 (Or) GA 1-0473
Butler, Edward J., Jr., (*Pawtucket*) 387 Broadway, Pawtucket PA 3-5780
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2. Ingegno, A.P.; and Kertzner, Leonard: New York Jour. Med., 54:1185, Apr. 15, 1954.

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Pawtucket, Rhode Island
on
WEDNESDAY, NOVEMBER 9, 1955
LOCATION: Auditorium, Brewster Street

MORNING SESSION (10:00 A.M. to 12:30 P.M.)

PRESIDING: Earl J. Mara, M.D.

10:00 to 10:15 "PRESENT-DAY TREATMENT OF SKIN DISEASE"
William B. Cohen, M.D.

10:20 to 10:35 "TREATMENT OF COLLES FRACTURE WITHOUT ANESTHESIA"
Raymond H. Trott, M.D.

10:40 to 11:00 "DISCUSSION OF CONGENITAL HEMOLYTIC ANEMIA DUE TO SERO-CYSTOSES. REPORT OF FOUR CASES"
Phillip J. Lappin, M.D.

11:05 to 11:25 "CROSSROADS OF ADOLESCENCE"
Stanley H. Cath, M.D.

11:30 to 11:50 "THE ROLE OF THE GENERAL PRACTITIONER IN COLON DISEASE"
Thad A. Krolicki, M.D.

11:55 to 12:15 "TESTICULAR TUMORS"
Ferdinand S. Forgiel, M.D.

12:20 to 12:35 "COMMON DERMATOSIS OF INFANCY AND CHILDHOOD"
Earl F. Kelly, M.D.
Bencel L. Schiff, M.D.

12:40 to 1:55 BUFFET LUNCHEON

AFTERNOON SESSION (2:00 P.M. to 5:00 P.M.)

PRESIDING: James P. Healey, M.D., *Chairman*
GREETINGS: Kenneth D. MacColl, President of the Memorial Hospital

SUBJECT: "PEPTIC DISORDERS OF THE ESOPHAGUS, STOMACH AND DUODENUM"

Panel—Dr. Franz J. Ingelfinger, Chairman

Associate Professor of Medicine, Boston University, School of Medicine, Boston, Mass. Visiting Physician, Massachusetts Memorial Hospitals, Boston, Mass.

Dr. Lloyd E. Hawes, Chief Radiologist, Faulkner Hospital, Jamaica Plain, Mass. Consultant, Boston V.A. and West Roxbury V.A. Hospitals, Boston, Mass.

Dr. Arnold S. Relman, Assistant Professor of Medicine, Boston University, School of Medicine, Boston, Mass. Attending Physician, Massachusetts Memorial Hospitals, Boston, Mass.

Dr. Reginald H. Smithwick, Surgeon in Chief, Massachusetts Memorial Hospitals, Boston, Mass. Professor and Chairman of Department of Surgery, Boston University, School of Medicine, Boston, Mass.

Dr. Lamar Soutter, Associate Professor of Surgery, Boston University, School of Medicine, Boston, Mass. Visiting Physician, Massachusetts Memorial Hospitals, Boston, Mass.



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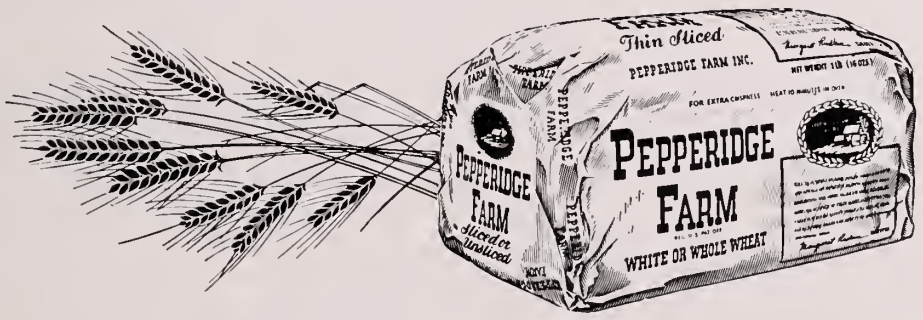
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SEGMENTAL ARTERIAL OCCLUSIONS TREATED WITH RESECTION AND GRAFTING

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However, at operation, the process was found to be generalized. The shunt type of graft proved to be satisfactory in this instance even though the distal anastomosis was to the popliteal artery. Nabseth[9] states that in a series of six cases where shunt grafts were used and a distal anastomosis occurred at the popliteal artery, there have been five failures. One of the failures was due to infection and four due to thrombosis of the shunt graft. He believes that the thrombosis occurs because of an inadequate popliteal channel.

The following two cases represent emergency situations, but are included here because homologous arterial grafts were employed.

Case IX. F.C. A seventy-six-year-old alcoholic who is said to have been lying on a doorstep for two days prior to admission. On examination, there was complete paralysis and coldness of both lower extremities to the level of the groins. He was explored immediately for a saddle embolism. However, at operation, he was found to have a thrombotic occlusion of the distal aorta and iliac vessels. The distal aorta and iliac vessels were resected and a bifurcation homologous aortic graft implanted. The patient went into shock four hours postoperatively and expired eight hours later.

Case X. K.W. A thirty-seven-year-old white male truck driver fell asleep at the wheel at midnight on April 23, 1955. He was thrown clear of the truck and was admitted to an out-of-town hospital at 2:10 A.M. Because he was in shock and there was concern about intra-abdominal injuries, it was not noted until 6:00 A.M. that the left arm was cyanotic, pulseless and flaccid. Nine hours after the injury, another surgeon in this hospital explored the left subclavian and brachial vessels and found them to be divided and completely occluded with fresh clot. All three brachial plexes cords were also completely severed. The brachial vein was ligated and a portion of the contused subclavian and axillary artery was resected and replaced with an autogenous saphenous vein graft. This graft was seen to be non-functioning at the end of the operative procedure, and there was no improvement in the left arm. Re-operation was begun at approximately 8:00 P.M. The sub-clavian artery was found to be contused and thrombosed proximal to the vein graft. Re-resection was carried out and a homologous arterial graft inserted. The final anastomosis was accomplished approximately twenty-four hours from the time of injury. A retrograde flush using heparin solution was carried out through the radial artery at the wrist prior to completing the distal anastomosis. On releasing the clamps, blood was seen to appear in the wrist

wound. However, gangrene of the left hand occurred and demarcation occurred at the level of the left forearm. At mid-humeral amputation, the muscles were found to be necrotic.

In view of the complete severance of all three brachial plexes cords, the salvage in this case would probably have been a flail arm. It was felt that if circulation could have been restored, it might have been possible later to accomplish nerve reconstruction. However, prolonged ischemia had resulted in muscle necrosis by the time the arterial graft was functioning.

Results

The follow-up period of observation on this series of cases varies from two to eight months and is far too short for long-term evaluation of arterial grafting procedures in the patient with generalized arteriosclerosis. Evaluation of the results in this group has been based largely on clinical factors:

1. Restoration and persistence of pedal pulses.
2. Healing of gangrene and trophic ulcers.
3. Relief of intermittent claudication.
4. General symptomatic improvement.

Those patients who obtained satisfactory results from grafting and were facing amputation prior to operation satisfied these criteria. Post-operative angiograms were considered hazardous in this group of patients and therefore have been avoided where a good clinical result had been obtained. Grading of results has not been necessary and as can be seen in Table III, a good result has meant preservation of the already doomed extremity. Failure in each instance has resulted in loss of limb.

TABLE III

Overall Results of Arterial Grafting

No. of Grafts	Good Result	Failure
10	6	4

Three of the four failures occurred in emergency situations which were accepted for surgery as almost hopeless (Cases VI, IX, and X). The fourth failure can be considered avoidable since it resulted from infection and resulting distal thrombosis (Case III).

In Table IV, the results of various vessels treated are compared.

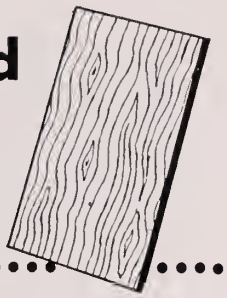
TABLE IV

Comparison of Location

	Clinical Results	
	Good	Bad
Aorta		1
Common Iliac	1	
External Iliac		1
Superficial Femoral	4	1
Femoral to Popliteal	1	
Subclavian		1

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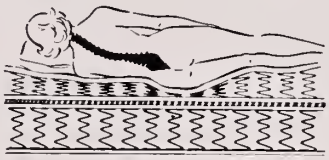
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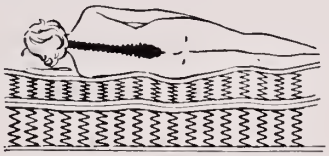
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SUMMARY AND CONCLUSIONS

An attempt has been made to evaluate the results of arterial grafting procedures in a small number of generalized arteriosclerotic patients exhibiting discrete segmental occlusions. Since these patients were already facing amputation because of trophic changes such as ulcers, gangrene, and rest pain, it is felt that this group represents the most difficult problem to deal with. The only prerequisite was angiographic evidence of a patent popliteal artery distal to the segmental occlusion. During a follow-up period of observation from two to eight months and ten operative procedures, good results have been obtained in six of the cases or 60%. Where the operation resulted in failure, amputation occurred in each instance. Since these limbs were already doomed to amputation, it would seem that the risk involved was worth while. Sepsis occurring at the graft site is a definite hazard and resulted in one of the failures. The results of resection and grafting for acute thrombotic occlusion has been universally bad in this series. Although this series is small, it would now appear that resection and grafting procedures may prove helpful in carefully selected cases of diffuse arteriosclerosis when there is impending gangrene.

Selection depends on arteriographic evidence of a patent artery distal to the occlusion suitable for anastomosis.

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Most of the 100 physicians enrolled in the division have attended special training meetings conducted by Doctor McDuff and are well acquainted with the objectives in terms of "fair share" giving which are being sought.

"No one group of people in the state," said Doctor McDuff, "should have greater knowledge and appreciation of the work of the United Fund agencies and the essential nature of their humanitarian services to people in need. We are intimately acquainted with hospital, clinic, and nursing services which are supported by the United Fund, and we are equally aware of how much is done by the Red Cross, the Multiple Sclerosis Society, the Parents' Council for Retarded Children, Children's Friend and Service, and the Child Guidance Clinic. These are only a few of the agencies which help the whole community, including our own patients, and we intend to support all of them through the United Fund. Further than that, we believe in the idea of federation and in one campaign for all causes."

Help for thousands of children, for men and women of all races, color and creed, and for families in trouble depends upon the public's response to the *First Annual Appeal* of Rhode Island's new United Fund, which provides the money needed by our health, welfare and recreational agencies operating in 21 Rhode Island cities and towns.

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BEGINNINGS OF MEDICAL EDUCATION IN RHODE ISLAND – PART II

continued from page 560

and apparently was ready to accept the inevitable in the face of what he considered the greater good of the college. At any rate it soon became clear that men in active practice, poorly paid by the college and dependent for a livelihood on their physicians' fees, could not long continue. As it came to the attention of the community that a number of eminent professors had been released, there ensued a running controversy in the local press. Most of the feeling, however, seems to have been engendered by the dismissal of Tristam Burges from the chair of Oratory and Belles-lettres. U. S. Representative from Rhode Island, he was a prominent lawyer, orator, politician, and a very popular figure locally. He was nevertheless subject to the same code as the others and suffered the same fate. An editorial of 1830, however, stated that: "Some of the most able professors that formerly graced this institution have been dismissed, almost with insult, and nearly the entire course of lectures in different branches of science, which alone formed any pretense for denominating the institution a University, have been dispensed with, without an effort on the part of the Corporation to preserve these advantages to the students." Professor C. W. Parsons weighed the gains in closer teacher-pupil relationship and in moral and mental development against the advantages of welcoming "men of distinction and power . . . engaged in . . . active pursuits outside the college, who bring with them a breath from the conflicts of mature life." He concluded: "In drawing the reins up so suddenly and turning so sharp a corner, it was not strange that something should be jolted out, and the medical school had the loosest hold." Professor Waite comments somewhat obliquely: "This may be considered the first attempt to install full-time medical teachers."

Medical School Contributions

During its brief history the medical school made a not inconsiderable contribution to medical education. No complete roster of the students is now available, but the number in attendance appears to have fluctuated between twenty-five and fifty. There is slight variation in the number of graduates attributed to the school, but C. W. Parsons who lists them by name identifies eighty-eight. Of these, twenty had previously received an A.B. from Brown or some other college. In addition between 1804 and 1828 thirty-one honorary M.D. degrees were awarded.

A list of those receiving honorary M.D.'s reads like a medical "Who's Who" of the period, including such names as Solomon Drowne, Pardon Bowen, Levi Wheaton, William Corlis Bowen, William Ingalls, John Mackie, John Mathewson Eddy, William Blanding, Caleb Fiske, David King (the leading physician of Newport) and Usher Parsons. Among the graduates in course a number became prominent members of the profession locally. Lewis L. Miller, Class of 1820, who practiced in Providence for forty years, became an eminent surgeon and served as president of the Rhode Island Medical Society in 1846-47. George Capron, Class of 1823, who practiced for fifty years, was [according to his obituary] "physician to the United States Marine Hospital in Providence" and president of the Rhode Island Medical Society in 1850-51. He contributed a number of papers to the medical literature. Francis L. Wheaton, Class of 1826, was commissioned surgeon-general of Rhode Island during the Mexican War and served as a surgeon in the armed forces throughout the Civil War. Hiram Allen, Class of 1825, who practiced in Woonsocket, became president of the Rhode Island Medical Society in 1851-52. Most of the other graduates became useful members of the profession.

A few attained prominence beyond the confines of the state. Doctor Jerome V. C. Smith, Class of 1818, served as port physician of Boston for twenty-three years, taught at Berkshire Medical College, contributed numerously to the medical literature and edited the Boston Medical and Surgical Journal for twenty-eight years. He was elected mayor of Boston in 1854. Doctor Alden March, Class of 1820, founded Albany Medical College where he served as president and professor of surgery. He became a distinguished surgeon in Albany and was recognized nationally by his election to the presidency of the American Medical Association.

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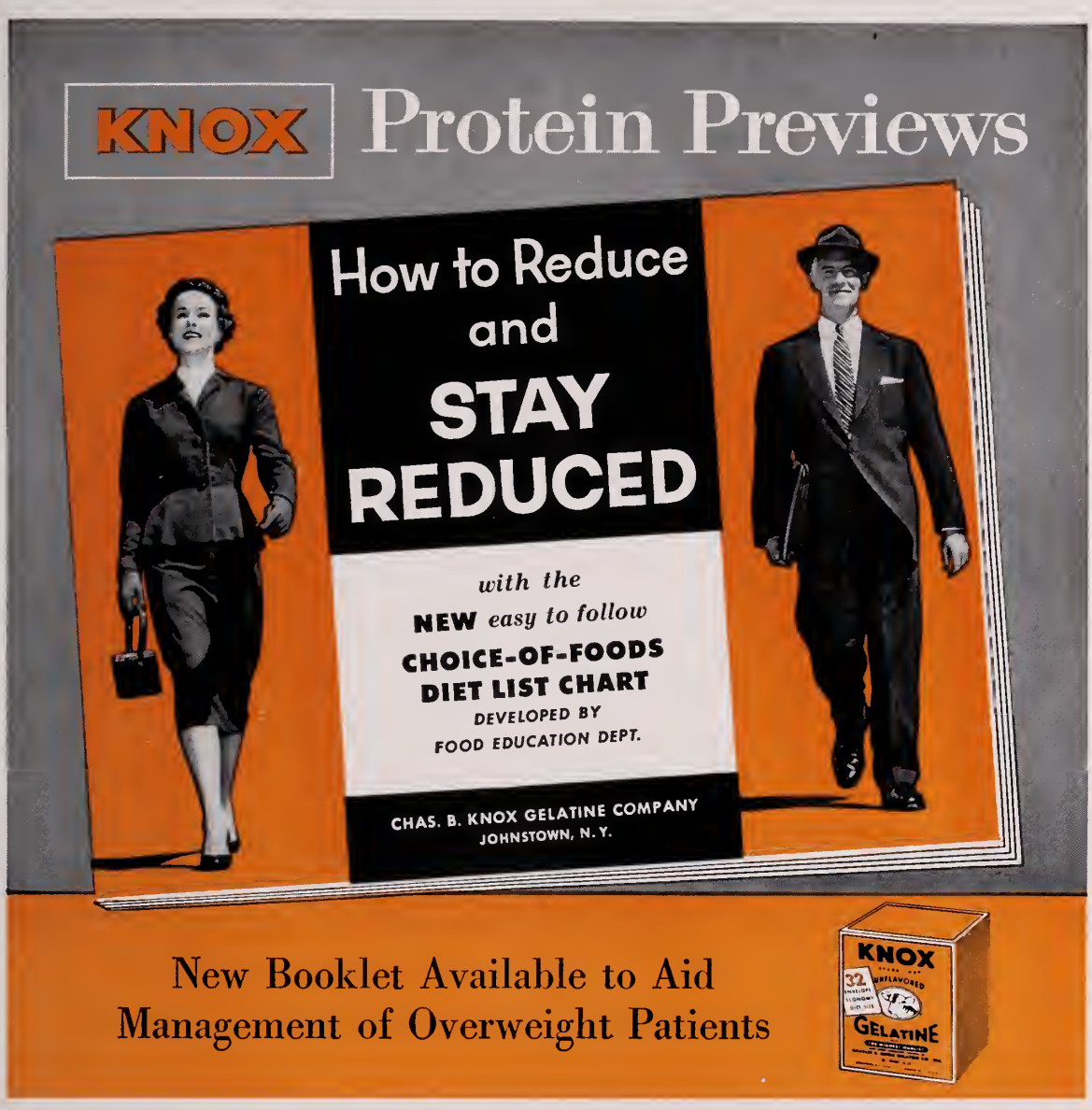
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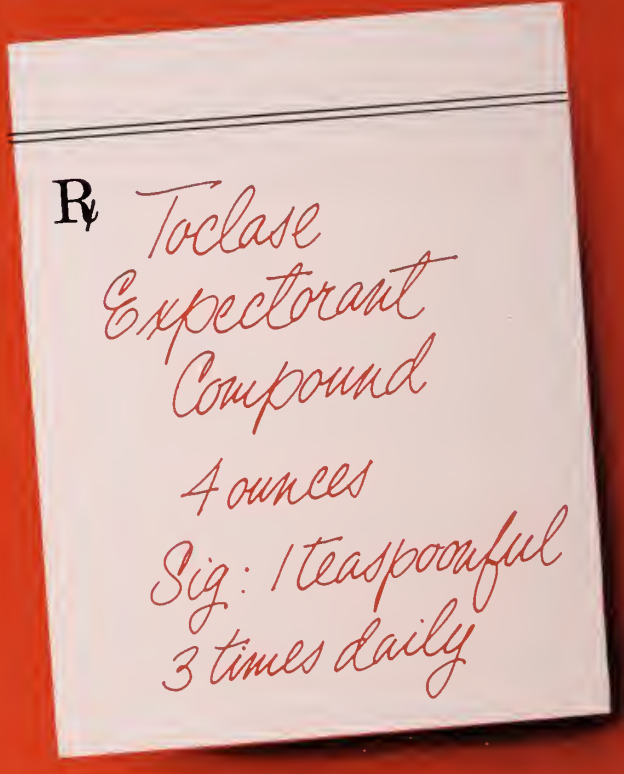
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BEGINNINGS OF MEDICAL EDUCATION IN RHODE ISLAND — PART II

continued from page 590

The most distinguished of all was Dr. Elisha Bartlett, graduate of the Class of 1826, the last under the administration of President Asa Messer. After a year of study in Paris, which had a considerable influence on his medical thinking, he settled in Lowell, Massachusetts, where he was elected mayor and later state representative. In 1832 he was appointed to the chair of Anatomy and Materia Medica at Berkshire Medical Institute at Pittsfield, Massachusetts, fulfilling his ambition to enter the teaching profession. He held this appointment for eight sessions. "For many years," wrote William Osler, "there was in this country a group of peripatetic teachers who like the Sophists of Greece, went from town to town, staying a year or two in each, or they divided their time between a winter session in a large city school and a summer term in a small country one." Associating himself with these wandering professors, Bartlett taught in a total of nine schools. These included Dartmouth, Transylvania University at Lexington in Kentucky, University of Maryland, Vermont Medical College, University of Louisville and Woodstock in Vermont. His career reached its culmination in 1852 when he was appointed to the chair of Materia Medica and Medical Jurisprudence at the College of Physicians and Surgeons in New York. He resigned after only two years because of ill health, having been affected by an obscure neurological disorder. He retired to his native Smithfield, Rhode Island, where in 1855 he died an untimely death in the fifty-second year of his life. He was a popular and magnetic lecturer and gifted as a public speaker, essayist and poet. His lasting fame rests mainly on two contributions to the medical literature: "The History, Diagnosis and Treatment of the Fevers of the United States," published in 1842 under a longer title and "An Essay on the Philosophy of Medical Science" in 1844. The first mentioned work which went through several editions gave the first clear-cut differentiation between typhus and typhoid fevers. The latter, a classic of American medical literature, defined with great clarity the basis for a rational and scientific approach in medical investigation. He was himself the subject of a brilliant biographical sketch by William Osler titled, "A Rhode Island Philosopher, Elisha Bartlett," briefly quoted above, which was first read before the Rhode Island Medical Society on December 7, 1899. Wrote Donald Fleming in his essay "Science and Technology in Providence 1760-1914" published in 1952: "He is a sufficient justification of medical education at Brown."

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Although the activities of the Medical School came to an end in 1827 there remained some unfinished business. On September 5th of that year the following letter was addressed "To the Fellows of Brown University":

Gentlemen,

William S. Stanley, Elihu White & Francis L. Wheaton, having fulfilled the requisite conditions as Medical Students—we, after due examination & inquiry beg leave to recommend them as candidates for the degree of Doctor of Medicine.

respectfully

Solomon Drowne
Levi Wheaton

Providence Sept. 5, 1827

This courteous request appears to have gone unheeded, as a year went by without any action being taken. Then followed this somewhat sharper communication:

To the President & Fellows
of Brown University

Gentlemen,

Permit us to recommend as candidates for the degree of Doctor of Medicine William S. Stanley, Elihu White, & Francis L. Wheaton—they having complied with the rules & regulations hitherto required at this University—with the expectation of receiving that honour to which we think them entitled.

respectfully

Solomon Drowne
Levi Wheaton

The result in this instance apparently was satisfactory, thus bringing to an end a brief but eventful era.

(to be continued)

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BOOK REVIEWS

CLINICAL BIOCHEMISTRY. A. Cantarow and M. Trumper. W. B. Saunders Co., Philadelphia, 5th ed., 1955, 738 pp.

This standard text is probably the most comprehensive work available on the clinical interpretation of biochemical laboratory findings. The present edition has been revised extensively to incorporate new material and concepts introduced in the six-year period intervening since the appearance of the fourth edition. Emphasis throughout is on clinical application; this is not a book on "methods" nor on the "fundamentals" of biochemistry.

Approximately the first half of the book approaches the subject from the standpoint of chemical entities with chapters on the metabolism of carbohydrates, lipids, proteins, nucleic acids, hemoglobin and porphyrins, calcium and phosphorus, magnesium, iron, sulfur, iodine, and sodium, potassium and chloride. Intermediate chapters deal with water balance, acid-base balance, respiratory exchange and basal metabolism, and an exceptionally complete discussion of hormone assay and endocrine function. Discussion of vitamins is limited chiefly to normal findings and methods for demonstration of deficiencies in man. The remainder of the text is functional in approach with chapters on gastric, pancreatic, hepatic and renal function. A final chapter discusses the biochemistry of spinal fluid.

One of the best features of Cantarow and Trumper is the complete index, comprising in the present edition no less than 99 pages. This, of course, greatly facilitates the ease of pinpointing the answer to a specific question. On the other hand, direct references to the original literature have now been replaced by brief lists of selected reviews and monographs on the more important topics. This will no doubt result in difficulty in locating original supporting data for some of the statements made.

This book is full of authoritative information. It is highly recommended as a valuable reference work to bridge the gap between basic biochemistry and clinical medicine.

WENDELL T. CARAWAY, Ph.D.

COLLINA, G.: Il problema del cancro visto dal medico pratico (The problem of cancer as seen by the general practitioner), Lega, Faenza, 1955

In this 463-page monograph, Collina offers to the general practitioner a remarkable ensemble work on cancer; a quick survey of practically all that has been recently done in the various specialized fields of research on the subject.

The book is divided into several sections, biology and experimental physiopathology, genetics, pathology, human chemistry, biochemistry and physiopathology, the psychology of cancer sufferers, the multitude of hypothetic etiologies, the prophylaxis and public assistance.

The book, while certainly valuable to the general practitioner in Italy, will also be of interest to the student outside Italy, because of its extensive reference to European and particularly Italian investigations which are usually out of reach of the English-speaking researcher. On this point it should prove to be a wealth of information.

The author discusses at length castration and hormone therapy, and adds the histories of twenty-seven personally followed cases so treated, with great success.

Skin cancer does not have a special chapter, but the use of podophyllin as well as the negative results of the ultrasonics in cancer of the skin are mentioned.

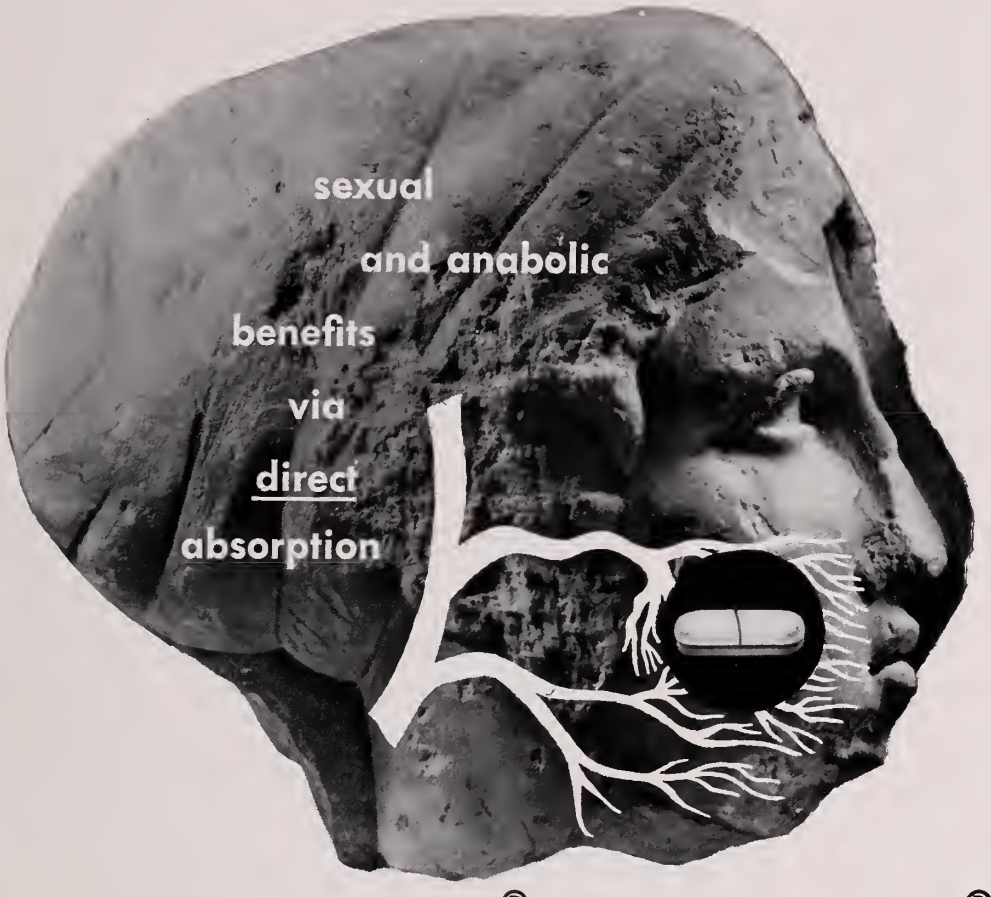
In regard to the attitude toward the cancer sufferer, Collina advises the family physician to "fasciare la veritá col dubbio scientifico" (cover the truth with the uncertainty of science). Even though (unfortunately) extremely rare, there are cases declared hopeless, in which the patient recovered for reasons unknown to science.

In regard to cytology, he agrees with the authors who believe this method gives an orientation toward a diagnosis only.

A most useful book for the practitioner and for those interested in foreign literature, and who are able to master the Italian language.

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Racioppi, Frank A., (*Kent*) 525 Providence Street, Natick ..... VA 1-2521
Rakatansky, Nathan S., 34 Old Tannery Road, Providence (Anes) ..... PL 1-7821
Ramos, Jose M., (*Newport*) 28 Kay Street, Newport ..... Newport 85
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Reeves, James A., 1404 Broad Street, Providence 5 ..... HO 1-2224
Regan, John F., State Hospital for Mental Diseases, Howard (P) (HAd) ..... HO 3-8100
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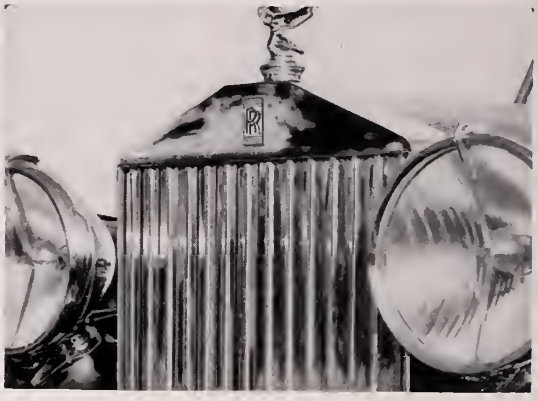


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AMA Clinical Session . . . at Boston . . . November 29 – December 2

AMA CLINICAL SESSION AT BOSTON

November 29 . . . December 2

THIS YEAR'S American Medical Association clinical meeting in Boston November 29 through December 2 is expected to be the largest ever held, the A.M.A. has announced.

The postgraduate education meeting, aimed at helping to solve the daily practice problems of the family physician, is expected to be attended by some 4,000 persons, a large increase over last year's meeting. About 200 scientific papers and exhibits have been scheduled for presentation, according to Doctor Thomas G. Hull, secretary of the A.M.A.'s Council on Scientific Assembly.

Meetings will be held in Mechanics Hall and at the Statler Hotel where the House of Delegates, the A.M.A.'s policy-making body, will hold sessions. Papers will be given in three lecture halls, offering the physician a wide variety of choice in subjects.

This ninth clinical session has been planned with the co-operation of organized medicine throughout all the New England States. Area medical societies have relinquished many meetings this year in order to give more time to the clinical session. General chairman for the meeting is Doctor Frank P. Foster, and Doctor Theodore L. Badger is program chairman. Both are from Boston.

Among the 100-plus scientific exhibits scheduled will be displays on fractures and deliveries. The obstetrical section will include manikin demonstrations of deliveries. Leading surgeons and obstetricians will be availaible for individual problem discussions.

Closed circuit television programs, originating in New England Deaconess hospital, will bring live operations in color to the lecture hall. The program is again being sponsored by Smith, Kline and French Laboratories of Philadelphia.

More than 50 motion pictures will be shown during the meeting, in the Paul Revere Annex of Mechanics Hall. A new medical film will be premièred at a special program at 8 P.M., Wednesday, Nov. 30, in the Georgian Room of the Statler Hotel. Following the première will be a special film and discussion on Total Right Hepatic Lobotomy by Doctors George T. Pack and Richard D. Brasfield, Memorial Hospital, New York City.

The technical exhibit will have more than 150 displays by medical equipment and pharmaceutical manufacturers, food processors, medical book publishers and other commercial organizations.

The General Practitioner of the Year will be named during the meeting. Last recipient of the award, chosen in Miami, was Doctor Karl Pace of Greenville, S. C.

An entertainment sidelight of the meeting will be a special concert for registrants by the Boston Symphony on Thursday, Dec. 1. Tickets will be given at the registration desk in Mechanics Hall, courtesy of Winthrop Stearns, Inc., New York pharmaceutical house.

BOOK REVIEWS

CHRISTOPHER'S MINOR SURGERY. Edited by Alton Ochsner, M.D. F.A.C.S. and Michael E. DeBakey, M.D. F.A.C.S. Seventh edition, W. B. Saunders Co. Phil., 1955. $9.00

This new edition of a surgical classic should prove a valuable reference for any doctor whose patients require surgery. It has been completely revised and rewritten. In modernization the high standards of previous editions have been maintained and in many instances surpassed. The authors of the various chapters include such authorities as Drs. Cooley, DeBakey, Lyons, and Ochsner with a heavy representation from the Tulane and Baylor schools of medicine. The scope of the material has been extended to include almost all surgery which does not involve entry of a major body cavity. The conditions are arranged by system and by region. Pathology, diagnosis, and the techniques of therapy are discussed clearly, concisely, and authoritatively with ample illustration. The procedures described vary from those that may be reasonably performed in the office or clinic, to those requiring the services of a well-equipped operating suite. The details of pre- and post-operative care are emphasized, as well as the techniques of operation. Since such a wide range is covered with such lucidity this text should occupy a prominent and often consulted position in any medical library.

PAUL B. METCALF, JR., M.D.

MEETINGS AHEAD

Monday, November 7 . . .

PROVIDENCE MEDICAL ASSOCIATION at the Medical Library, 8:30 P.M.

HARRY C. SOLOMON, M.D., Professor of Psychiatry at Harvard Medical School, speaks on

"PSYCHIATRY . . 1955 Model"

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Wednesday, November 9 . . .

JOHN F. KENNEY MEMORIAL CLINIC DAY, at Memorial Hospital, Pawtucket

(See page 570 for complete program)

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Wednesday, November 16 . . .

DIABETES FAIR at Miriam Hospital

□□□□□□□□□□□□

Monday, November 28 . . .

A.M.A. PUBLIC RELATIONS CONFERENCE at Boston

□□□□□□□□□□□□

Tuesday, November 29 through Friday, December 2 . . .

CLINICAL SESSION OF THE AMERICAN MEDICAL ASSOCIATION at Boston

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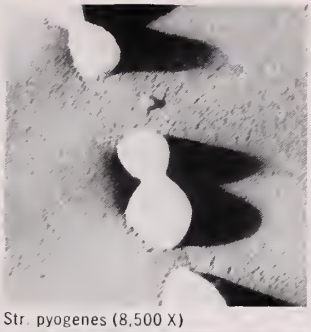
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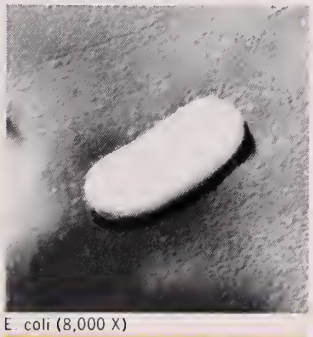
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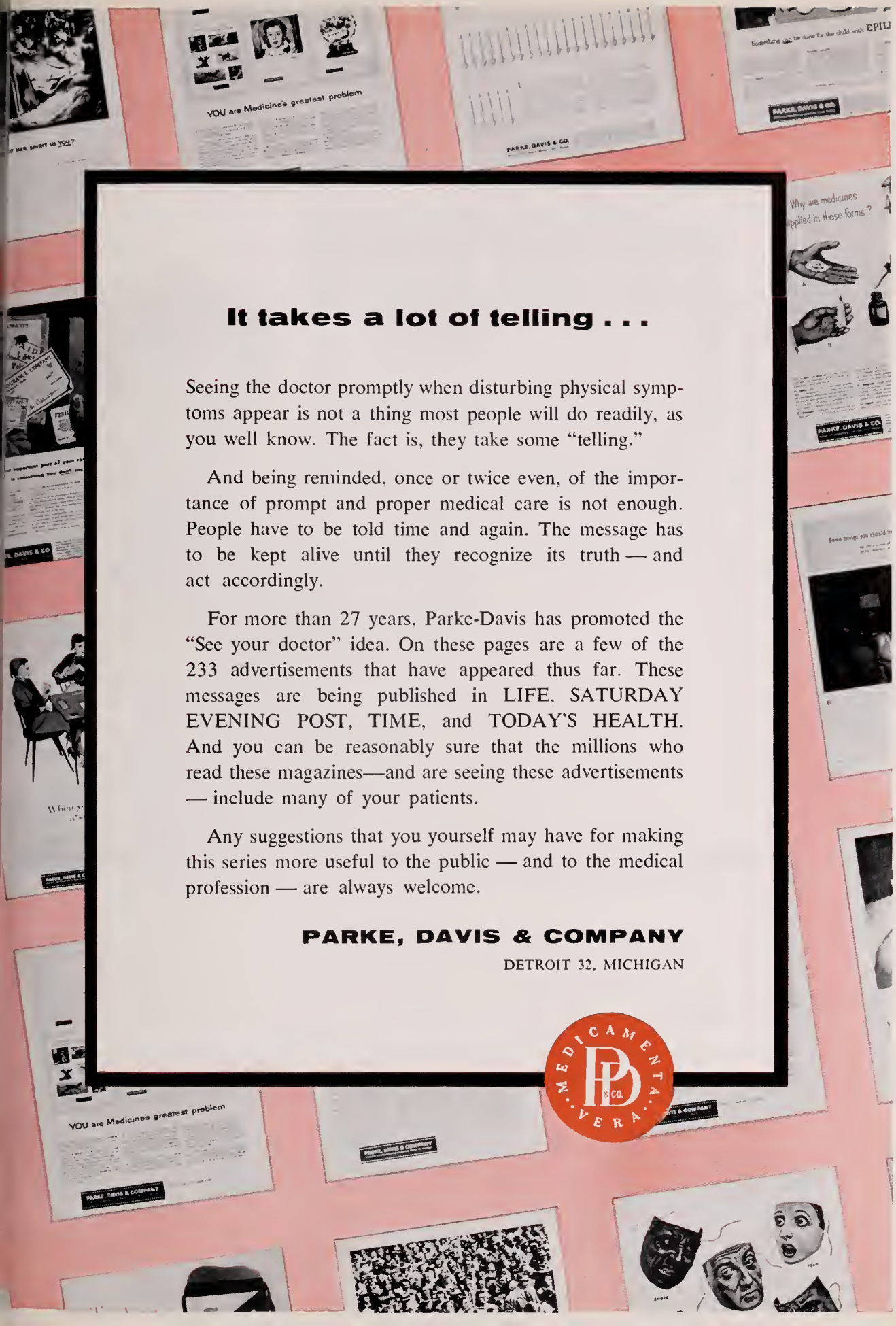
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(1) Payne, R. W.; Shetlar, M. R.; Farr, C. H.; Hellboum, A. A., and Ishmael, W. K.: J. Lab. & Clin. Med. 45:331, 1955. (2) Bunim, J. J.; Williams, R. R., and Black, R. L.: J. Chran. Dis. 1:168, 1955. (3) Holbraok, W. P.: M. Clin. North America 39:405, 1955.

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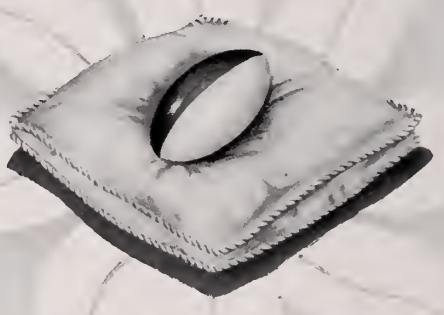
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2. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery 18:512, 1949.
4. Turell, R.: New York St. J. M. 50:2282, 1950.

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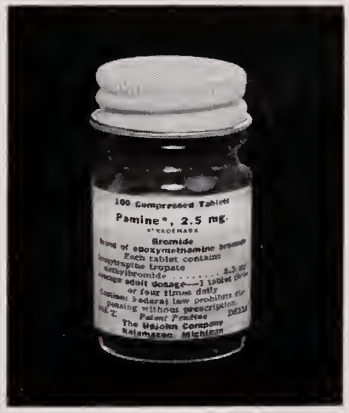
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXVIII NOVEMBER, 1955 NO. 11

RHEUMATOID ARTHRITIS

Fifteen Years' Experience With Chrysotherapy

José M. Ramos, M.D.

The Author. *José M. Ramos, M.D., of Newport, Rhode Island. Senior Physician and Director of Arthritis Clinic, Newport Hospital.*

A. History of Chrysotherapy

The use of gold as a therapeutic agent for rheumatoid arthritis is not new. Lande, in Germany, was the first reported to have used this agent for this disease as far back as 1929, but the greatest impetus to its use was given by Jacques Forestier at Aix-les-Bains, France, in 1929.

His use of this form of therapy was based on the knowledge that gold salts could inhibit growth of tubercule bacilli in vitro. This fact had been reported in 1890 by Koch. Later, other workers reported that gold preparations containing a sulfhydryl (SH) group possessed antibacterial properties, and much was done in the study of gold preparations in treating skin disorders which were considered to be related to tuberculosis such as lupus erythematosis, eczema and psoriasis.

Because of some clinical similarities between rheumatoid arthritis and tuberculosis, it seemed reasonable to Forestier to assume that gold salts might help the rheumatoid patients. This reasoning was also based on the knowledge that gold had an affinity for serous membranes such as the pleura and the synovial membranes. As Copeman and his workers had realized, gold was present in the synovial membranes in much higher concentrations than in the muscle, and that the gold content of the synovial membranes of the arthritic joints was much higher than in the synovial membranes of normal joints.

During the past ten years much has been learned concerning the gold compounds, their pharmacology and metabolism and this has made for a more intelligent use of gold in its application to rheumatoid activity.

B. Mode of Action

The way in which gold compounds act in the human organism when used for treatment of rheumatoid activity is still a matter of conjecture. Various tissue biopsies of patients who had received radioactive gold as gold sodium thiosulfate showed that there was a much higher concentration in the synovial membranes and fluid than in muscle, fascia or skin. It is varied mainly in the plasma components of the blood, most probably bound to the plasma proteins.

The failure of gold to protect guinea pigs against large doses of histamine, and the absence of an effect of Arthus phenomenon did not suggest that it had an antiallergic action.

Since particles of gold had been found in the reticulo-endothelial cells, it was thought that possibly gold stimulated the reticulo-endothelial system. There has been no evidence to support this theory.

Another theory suggested that gold compounds might exert their therapeutic effect by changing tissue enzyme reaction. In vitro studies on rat tissues failed to confirm this hypothesis.

Lately some workers have had the opinion that gold compounds may, perhaps, stimulate the adrenal cortex, and thereby produce their therapeutic effect. Much work was done to disprove this theory by Bruce and Mackay at the North Royal Infirmary, in Inverness, Scotland. They investigated to see what changes, if any, took place in the urinary excretion of neutral 17-ketosteroids in the cases that were selected for gold therapy, and found that chrysotherapy did not produce any change in the 17-ketosteroid excretion level in the cases that benefited from this therapy.

Davison, Koets, Kuzell and others also found the ketosteroid excretion to be within the normal range in these cases and suggested that cases of rheumatoid arthritis deriving benefit from chrysotherapy could not attribute their improvement to any action on the adrenal cortex.

C. Administration of Gold

There are various preparations of gold repre-

continued on next page

senting different chemical and physical types of gold compounds. The gold preparations most frequently used are: 1) Sanochrysine, a gold sodium thiosulfate solution, soluble in water and containing 37% gold. 2) Myochrysine, a gold sodium thiomalate, also soluble in water, and containing 50% gold. 3) Solganol-B Oleosum, a gold thioglucose in oil suspension and also containing 50% gold.

The latter form, or Solganol-B Oleosum, was used almost exclusively throughout these series of cases during at least twelve of the fifteen years of therapy of rheumatoid cases. During the first three years Gold Sodium Thiosulfate (Abbott) was used in intravenous doses of 10 and 25 mgm. Retrospectively one appreciates the latter method as having been really an heroic mode of therapy given its extremely rapid absorption and its high blood concentration a few hours after injection. The reactions to gold were frequent and sometimes severe depending upon the individual susceptibility.

An oil suspension of a soluble gold salt such as gold thioglucose given intramuscularly is slowly absorbed, and produces lower plasma gold concentrations with less frequency of reactions to gold. This oil suspension was used by us not because of its superiority to either Sanochrysine or Myochrysine, but merely due to the fact that it was a product that we had been accustomed to handling and were familiar with its various reactions and the various individual idiosyncrasies that were associated with it.

The all-important factor in the use of Chrysotherapy reduces itself to the routine in which the gold compound is administered, or the schedule that is applied in cases of rheumatoid activity.

Until 1945, the routine that was customarily used and applied in this office, was the administration of gold in graded doses beginning with 10 mgm. weekly for four weeks and then 25 mgm. weekly for four weeks with a continuance of 50 mgm. weekly until a total dose of 1 to 2 gms. of the drug had been administered. This routine was modified by the reaction of the individual to gold or interrupted entirely according to the severity of the toxic symptoms. A rest period of two months was then given and another course, or as many of four courses, were given until a satisfactory outcome was reached and no further relapses occurred. This was recognized as the method "ad modum Steinbrocker."

The method used by us since 1945 was a slight modification of this schedule, taking into consideration the fact that among patients receiving higher doses of gold compounds there was a tendency toward greater improvement but also towards increased toxicity. A fairly good compromise was reached with a schedule which, we think, gave good end results and at the same time circumvented the highly toxic reactions of the drug.

The average total dose of gold was 1.250 grams and given in this manner: for the first six weeks the patient received 25 mgms. of gold thioglucose every four days. It was during this period that the reactions to gold were the most frequent. At the end of this period 25 mgms. were given once weekly for six weeks; then 25 mgms. were given every two weeks for six doses. At this time the same doses were continued once every three weeks for six doses, and then once a month up to a period of two years from the beginning of therapy.

Up to the present time, after a ten-year period, we have seen but three relapses out of our total of thirty-six cases treated under this program. All three of these cases had had their therapy interrupted for a period of one year or more due to various domestic reasons.

One can readily appreciate the necessity of having the patient adhere rigidly to the program outlined to him beforehand.

The schedule last outlined, is developed more or less according to the precepts of Hartung, and in our hands has proven highly satisfactory thus far.

D. Selection of Cases and Diagnosis

The selection of cases suitable for gold therapy is an extremely important consideration and one about which there should be little or no debate. It postulates one's familiarity with the metabolism and pharmacology of gold and the nature of the disease to be treated.

First of all, one should be convinced clinically that the disease is that of rheumatoid activity, and secondly, one should explain to the patient that gold contributes only insofar as it arrests the disease but does not repair the damage done to cartilage and bones, nor does it restore deformed and ankylosed joints. It is also important, insofar as the patient and his financial economy are concerned, that one does not subject a patient *suspected* of rheumatoid activity to a course of three years of therapy uselessly, with all its attendant therapeutic complications.

The ideal objective in the treatment of patients with rheumatoid arthritis is to prevent crippling deformities and incapacitations and to have him restored as much as is possible, to complete rehabilitation. To wait until the gold treatment be used as a last resort is only fostering poor and unimpressive results, since joint damage has already taken place and the destructive changes already present cannot be remedied.

Proper use of gold salts in the early stages of rheumatoid arthritis with active synovitis produces gratifying results. It has been found by many workers that in the symptom-free group treated with gold most were treated within one year of onset of the disease.

It has been the opinion among many rheumatologists, however, that one should observe early cases during the first three months, not instituting gold therapy at the onset, but evaluating the progress of the disease at monthly intervals and resorting to physical therapy, intra-articular injections of Hydrocortisone acetate and active exercise. If gratifying results are obtained, then gold therapy is held in abeyance until such time as the disease seems to be advancing in spite of these measures last mentioned.

In choosing the specific cases for gold therapy certain criteria have been helpful:

1) X-ray findings are generally disappointing and one should not rely too much on this examination. However, punched-out areas of bone destruction in the subchondrial areas are significant especially if it is co-ordinated with the patient's history and clinical findings. Usually one finds these areas of decalcification or bone destruction in the metatarso-phalyngeal joints of the feet as the first manifestations. These appear under the big toe first since this is the point of greatest trauma.

2) The sedimentation rate is elevated in about 90% of the cases. However, in the remaining 10% where there is no elevation of the sedimentation rate one must rely upon one's clinical acumen and the other laboratory tests to give one the clue.

3) Protein Metabolism—many workers such as Wallis, Salt and Olhagen have found that in most cases of rheumatoid activity there is a tendency towards a reversal of the A-G ratio, a drop in the total serum protein level, an increase in the plasma fibrinogen, and a positive thymol turbidity test.

4) Agglutination of Sensitized Sheep Cells—apparently it is now well established that the serum of (more than half) of the rheumatoid patients will increase the specific agglutination of cellular antigens. In the work done by Ziff, Brown, Badin and McEwen, 92% of the patients with adult rheumatoid arthritis gave a positive test.

5) Lately it has been suggested that, in addition to employing the usual erythrocyte sedimentation rate, as a measure of rheumatoid activity, one resort to a method which has been found to be more reliable and more stable: The *serum polysaccharide-protein ratio.* The polysaccharide-protein ratio is obtained by dividing the polysaccharide concentration by the serum protein and multiplying the result by 100. An elevated serum polysaccharide-protein ratio occurs, apparently, in active rheumatoid arthritis and other collagen diseases. It can be utilized as a measure of the degree of clinical activity.

An increased clinical activity of the disease is accompanied by a proportionate rise in the polysaccharide-protein ratio, while a remission is attended by a fall in the ratio. This ratio remains constant in the normal individual and undergoes only slight change in minor infections or trauma. Although inflammatory states, neoplastic diseases and severe trauma seem to affect this ratio, they are *seldom* of a severity sufficient to bring about an alteration in it.

E. Effect of Gold in Applicable Cases

In cases of rheumatoid activity where conservative therapy has not produced gratifying results within the first three months, and gold treatment is instituted at this time, one finds in the majority of cases an almost immediate response.

Following are the statistics on the thirty-six patients treated by us during the past fifteen years. They have been graded according to time in which loss of pain and oedema, return of mobility and complete rehabilitation took place after therapy.

Months	1	2	3	4	6	8	12	24
Loss of Pain	36%	48%		.02%	.02%		.02%	
Loss of Oedema	41%	50%		11%				
Return of Complete Mobility	25%	33%	.02%	30%	.8%			
Complete Rehabilitation	22%	25%		.8%	11%	.02%	.05%	13%

One patient had loss of pain after the first injection. This was a case of acute rheumatoid activity of three months' duration. Another patient had loss of pain only after one entire year of treatment. This person was an extremely hyperexcitable individual who suffered more muscle spasms than actual articular pain.

Before the twelfth week of gold therapy the majority of the patients were able to state that no longer were they susceptible to barometric pressure changes which had heretofore always heralded an onslaught of polyarticular pain and synovial sensitivity. This refractoriness to barometric pressure changes has been used as a criterion, in this office, for future steady improvement.

Practically all patients, once having gone beyond this hurdle, complain very little even after performing their usual routine, daily occupations.

We must mention that the entire period of gold administration was constantly accompanied by physical therapy and active exercises. This latter consideration is all important in the objective of complete rehabilitation of the patient.

F. Gold vs. Other Drugs

1. *Cortisone and ACTH.* Though Cortisone and ACTH have been effective in their anti-rheumatic activity, they have not been without their serious drawbacks and consequences. In addition to the

continued on next page

fact that rheumatoid cases would have to be placed under perpetual Cortisone therapy in order to avoid relapses, in which case the cost is staggering to the patient, the side reactions of these hormones under long-term therapy is well known.

The results produced upon withdrawal of the steroids have been studied by such workers as Ball of the Rheumatism Research Centre at the University of Manchester, England, and Slocum of the Mayo Clinic. They have shown that there exists a panmesenchymal and panangiitic reaction that carries all the risks of polyarteritis nodosa or of acute lupus erythematosis. The effects of these hormones are temporary and suppressive but not curative.

The intra-articular injections of a steroid such as Hydrocortisone Acetate in repeated injections offer a fairly consistent, long-lasting palliation but only time will tell whether the alleviating effect of this drug will result in long range benefits to the patient.

2. *Copper.* The use of copper salts such as Cupralene was introduced in 1949 by the Father of gold therapy, Jacques Forestier, of Aix-les-Baines, France. He advocated its use during the subacute stage of rheumatoid activity and claimed that they gave better results than gold salts in these cases. Work done in the United States with this therapy did not bear out his contentions, however.

3. *Butazolidin or Phenylbutazone.* In rheumatoid spondylitis Butazolidin is the drug of choice and the results have been found to be superior to either Cortisone, ACTH or X-ray therapy. However, the prolonged administration of the drug is accompanied by a great deal of danger toward agranulocytosis and must be given with the utmost care.

Like Cortisone and ACTH, Butazolidin does not arrest the disease but gives only temporary palliation.

G. *Gold Toxicity.* Toxicity from gold administration may manifest itself at any time after the initial injection. In our experience most of the manifestations of gold toxicity showed themselves within the first six weeks of therapy, the most frequent being skin rashes on the nature of an eczematoid dermatitis. Frequently one encountered patients who complained of a generalized pruritis without any evidences of a skin irritation.

Other manifestations of toxicity were: nausea, abdominal cramps and occasionally diarrhea, headache, sub-sternal oppression, vertigo and a metallic taste in the mouth. In one case there was a flare-up of giant hives or angio-neurotic oedema.

None of these evidences of toxicity was considered as a contra-indication to further gold therapy. After a resting period of three to four weeks, when all symptoms had disappeared, gold injections were resumed.

At no time, in our fifteen years of experience with Chrysotherapy, did we encounter a case of exfoliative dermatitis or agranulocytopenia due to bone marrow inhibition. Extreme caution upon the first manifestation of skin reactions perhaps helped to avoid the former danger, and the use of purified liver extract, 10 mcgr. per c.c., given with each gold injection perhaps helped to avoid the latter.

As it has been mentioned by Freyberg, there are many indications that gold toxicity in human beings is an allergic type of reaction. The fact that there is an occurrence of dermatitis of an eczematoid form after only one, two or three injections; the frequent occurrence of esinophylia preceding and during the toxicity; that some times there is a development of toxicity following a single, small injection of gold given after an interval of many weeks following completion of a course of gold that was well tolerated; all these point to an allergic concept.

It has been significant in our experience that those patients who were found to have an allergic substratum, either in the form of an allergic rhinitis, frank bronchial asthma, gastro-intestinal allergy or allergic dermatitis, were precisely those who manifested a gold toxicity. In all these cases the administration of Cortisone, either parenterally or orally, for three to four days subsequent to their injection of gold warded off all signs of toxicity, that had manifested themselves on previous injections.

Experience has shown that many conditions formerly thought to be contra-indications to gold actually are not. Allergic diseases no longer prevent the use of gold therapy since the concomitant administration of Cortisone can mitigate the toxic reactions.

Pregnancy is not necessarily a contra-indication, since many pregnant patients have tolerated the therapy well and with no untoward reactions to the child. Rheumatoid patients, however, are benefited by pregnancy and gold therapy is seldom desired throughout this period.

Serious kidney or liver disease with functional impairment of these organs, blood dyscrasias, hemophilia and severe anemia are considered to be definite contra-indications to gold therapy.

When gold therapy is beneficial, in the well-done cases, it is most gratifying to note the signs of inflammation decreasing, the gradual and progressive lessening of pain and the improvement in articular functioning. Thus far, gold is the only drug at our command that produces an arrest of the rheumatoid activity when employed in a well-planned program of treatment. After twenty-five years of use it remains as our only effective agent, and the availability of Cortisone and ACTH have helped us to reduce further the risks of toxic reactions.

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THE MEDICAL ADVISORY COMMITTEE AND THE DISABILITY FREEZE

CHARLES L. FARRELL, M.D.

The Author. *Charles L. Farrell, M.D., of Pawtucket, Rhode Island. Member, Medical Advisory Committee to the Social Security Administration; President, Conference of Presidents and Other Officers of State Medical Associations; President-elect, Rhode Island Medical Society.*

LAST FEBRUARY, a Medical Advisory Committee was appointed to advise the Social Security Administration in connection with medical policies involved in the new "disability freeze" provision. Medical practitioners may be interested in learning about the composition and activities of the Committee and of the operations of the "freeze" provision since many of their patients undoubtedly have rights under this provision.

The disability freeze provision permits a qualified individual to maintain his old-age and survivors insurance rights during extended periods when he is totally disabled by reason of a medically determinable physical or mental impairement.[1] For the long run, the determinations of disability will be made mostly by the vocational rehabilitation agency or by another appropriate agency in the applicant's own state, under agreements negotiated between the states and the Secretary of Health, Education, and Welfare. The Bureau of Old-Age and Survivors Insurance is responsible for making determinations in cases not covered by State agreements.

Determinations of disability are made with a "team" approach—i.e., by a physician and a qualified counselor or lay person skilled in evaluating the effect of impairments on ability to work. In many States the physician member of the "review team" is in private practice and serves as a consultant to the State agency for purposes of making freeze decisions. The role of the attending or examining physician in submitting the medical report is of paramount importance to the program, for it is on the basis of the clinical findings and other medical evidence in the report that a determination of the severity of the impairment is made. By submitting accurate, specific reports, the physician can render assistance to the applicant and at the same time facilitate fair and proper disposition of the claim.

[1]For an individual to become entitled to monthly old-age insurance (i.e., retirement) payments or for his family to become entitled to monthly payments in case of his death, he must meet a minimum work requirement under social security. The amount of his payments is then calculated from his average monthly earnings in work covered by social security. The new law preserves a disabled worker's rights and permits his period of disability to be excluded in determining the amount of his benefit.

The Purposes of the Medical Advisory Committee

In agreeing to serve on the Medical Advisory Committee, the members of the Committee affirmed their understanding that the disability freeze definitely does not include nor contemplate cash payments before age 65, nor any type of State or governmental treatment other than that now existing or available to the States under present laws.

Briefly, the purposes of the Medical Advisory Committee are:

1. To provide technical advice and consultation regarding medical aspects of the administration of the freeze provision.
2. To promote mutual understanding and effective working relationships among the Social Security Administration, cooperating State agencies, and physicians generally.
3. To provide professional guidance in formulating medical guides and standards for evaluating disability.

Composition of the Committee

The membership of the Committee represents a wide variety of skills in medical practice and public and private medical and welfare administration. The Social Security Administration and the State agencies administering the freeze provision would thus have the benefit of diverse professional experience. Among the professional and industrial groups represented on the Committee are general medical practice, internal medicine, physicial medicine, preventive medicine, ophthalmology, surgery, vocational rehabilitation, orthopedics, public health, labor unions, and social welfare agencies.[2] Insofar as possible the major geographical sections of the country are represented, also.

Accomplishment of the Committee

The Committee met with representatives of the Department of Health, Education, and Welfare in Washington in February, March, and May, 1955.

continued on next page

A report of its recommendations to date has been submitted and recently published.[3] Additional meetings will be held in the future.

One of the problems considered by the Committte relates to the responsibility placed on the applicant by law to furnish proof of his disability. To carry out this provision, the Committee found it reasonable for the Bureau of Old-Age and Survivors Insurance to advise the applicant to secure a *current* medical report from his own physician or from another medical source, hospital, clinic, or agency, based upon an existing medical record or upon a current examination. This report, if it is complete and factual, will ordinarily be sufficient to establish the degree of severity of the applicant's disability. In some cases there will be need for additional medical information, and occasionally, an additional examination. The "review team" may need additional reports of diagnoses and clinical findings from existing records, and will advise the applicant that he must secure these.

Where the initial medical report submitted by an applicant's physician *fails to establish the severity of the impairment, the physician in the administering agency may write directly to the applicant's physician for additional data.* It is believed that this approach will preserve and strengthen the doctor-patient relationship. If the necessary information cannot be provided by the attending physician without a further examination, the *applicant will need to be informed* and *must be responsible* for *any fee charges,* since it is part of the *applicant's own responsibility to prove his disability.* A medical examination at the expense of the Government may be authorized only in the exceptional case where, in the judgment of the review physician, it seems necessary to verify facts to insure that an improper award will not be made.

The Committee also considered operating instructions to be issued to State agencies and the medical criteria for evaluation of specific impairments and combinations of impairments. These proposed guides and standards were reviewed and analyzed by sub-groups of Committee members with specialized training and experience in the particular subject matter under study. The sub-groups made a number of suggestions to clarify the material and bring it into conformity with most recent developments in medical science. The Committee approved the use of the medical guides as an initial basis for operations during the coming months. These criteria establish a test of severity which an applicant's impairment must meet in order for him to qualify for the freeze.

How the Attending or Examining Physician Can Help

The Committee feels that practicing physicians should have a real understanding of the freeze provision since many of their patients will be asking them for medical reports to be submitted to the appropriate agency in their State to establish their disabilities. Ordinarily a person so severely disabled as to qualify for a freeze will be under the medical care of a physician or will have had a medical examination for his condition.

Medical reports are normally submitted directly to the Social Security Administration for transmittal (together with the application and other papers) to the State agency making the disability determination, rather than through the applicant. The report form calls for pertinent history, clinical findings and diagnosis. It is purposely short and simple, intended to be flexible. Use of any other form, or a narrative statement is acceptable, so long as the information contains the necessary facts relating to pertinent history, symptomatology, clinical findings and diagnosis. Because various State and Federal disability provisions established by law operate under legally defined concepts of disability, definitions among programs differ. Reporting physicians are not asked to decide whether the applicant is under a disability. Their responsibility, instead, is to give the agency medical facts and findings sufficient for its physician to reach a conclusion as to diagnosis and the severity of the impairment, and therefore determine whether the applicant meets the definition of disability for this program.

Experience to date with the medical report form has been generally good, but some of the reports received contain insufficient medical findings to permit a reviewing physician to evaluate the extent and degree of the impairment. In such case, it is necessary to ask the reporting physician to describe more precisely his findings. Consideration was given by the Medical Advisory Committee to revising the present form to call for more detailed information. However, it was agreed at the May meeting that the present medical report form could be used until more experience indicated the kind of revision necessary. Comments from practicing physicians are welcome. Their opinions are highly regarded and carefully considered.

SUMMARY

In February, the Commissioner of Social Security appointed a Medical Advisory Committee representative of different specialties, including general practice, and different geographical portions of the

[2]The Committee appointed by the Social Security Administration in the U. S. Department of Health, Education, and Welfare consisted of the following members: See list on page 629.

[3]*Medical Advisory Committee Report and Recommendations on the Administration of the OASI Disability Freeze Provision*—copies for sale by the Superintendent of Documents, Government Printing Office, Washington 25, D.C., at 10 cents per copy or 100 copies for $7.50.

country to advise him with respect to the medical policies involved in administration of the new disability freeze provision. The Committee has met, considered and approved for the early months of operation, proposed guides and standards fixing the responsibility for obtaining evidence of disability and the type and amount of evidence required to establish disability. Since the applicant has the responsibility of presenting proof of disability, he will need the cooperation of his attending physician. The latter should furnish the administering agency with a current report of medical findings sufficient to permit a decision to be made as to the severity of the impairment and whether the applicant is "disabled" as defined by law.

Medical Advisory Committee on Disability Freeze

Dr. J. Duffy Hancock, *Chairman.* President of the Southeastern Surgical Congress and Clinical Professor of Surgery at the University of Louisville School of Medicine. Louisville, Kentucky

Miss Pearl Bierman. Medical Care Consultant, American Public Welfare Association. Chicago, Illinois

Dr. Philip D. Bonnet. Administrator, Massachusetts Memorial Hospital. Boston, Massachusetts

Dr. Donald Covalt. Associate Professor, Department of Physical Medicine and Rehabilitation, New York University College of Medicine. New York, New York

Dr. Charles L. Farrell. President of the Conference of Presidents and Other Officers of State Medical Associations; President-elect, Rhode Island Medical Society. Pawtucket, Rhode Island

Dr. J. S. Felton. Associate Professor, Department of Medicine and Department of Preventive Medicine, University of Oklahoma. Oklahoma City, Oklahoma

Dr. Herman E. Hilleboe. Commissioner, State Department of Health. Albany, New York

Dr. Lemuel C. McGee. Medical Director, Hercules Powder Company. Wilmington, Delaware

Dr. Kenneth E. McIntyre. Director, Metropolitan Hospital, cooperating arrangements, United Automobile Workers CIO. Detroit, Michigan

Dr. William A. Pettit. State Supervising Ophthalmologist for the California Department of Public Welfare. Los Angeles, California

Dr. Leo Price. Director, Union Health Center, International Ladies' Garment Workers' Union. New York, New York

Dr. William Harold Scoins. Chief Medical Director, Lincoln National Life Insurance Company. Fort Wayne 1, Indiana

Carroll Shartle, ph.d. Professor of Psychology and Executive Director of the Personnel Research Board, Ohio State University. Columbus, Ohio

Mr. Byron Smith. Executive Secretary, Minneapolis Society for the Blind. Minneapolis, Minnesota

Dr. David Wade. Medical Consultant for the Texas Division of Vocational Rehabilitation. Austin, Texas

RHEUMATOID ARTHRITIS

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It is true that it is by no means an ideal drug, and improvements in treatment for rheumatoid arthritis may develop in such a trend as to eliminate the need for gold therapy. At that time all those engaged in chrysotherapy will be the first and the happiest to abandon it in favor of superior treatment.

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PHLEBITIS*

JOHN J. BYRNE, M.D.

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At the Reunion Day of St. Joseph's Hospital Staff Association on September 7, 1955, Dr. John J. Byrne was one of the group that gave a symposium on "Peripheral Vascular Disease." His talk on "Thrombophlebitis" was a most interesting one and he backed it up with a large number of excellent statistics. Statistics are valuable, but they do not make especially lively reading, and as the aforesaid statistics have been given elsewhere, we asked him if he would not write us an article giving his views and allowing us to certify the excellence of the statistics. He promised to do this and we are greatly pleased to present at this time his ideas on phlebitis.

THE EDITOR

THERE IS much confusion about the best treatment of phlebitis. The most important reason for this is the lack of knowledge of the basic cause of the disease. Until we can find the essential factor that produces phlebitis, we will be at our wits' end in treating it.

We know there are three general factors capable of initiating thrombosis: damage to vein intima, stasis of the circulation, and increased coagulability of the blood. The intima of the vein may be altered by trauma, infection, chemical agents, and even hypoxia. Processes which may produce circulatory stasis are heart disease, varicose veins, pregnancy, hemiplegia, bed rest, tight abdominal binders, obesity, shock, and diminished respiratory ventilation. Changes in the coagulability of the blood are known to be associated with the postoperative period, blood dyscrasias (polycythemia vera), neoplasm, infection, and dehydration.

Although we do not know the cause of phlebitis, we are certain of the diseases which predispose to it. A recent study of a large series of patients at the Boston City Hospital revealed the following diseases to be associated with phlebitis in this order of frequency: cardiac disease, postoperative state, trauma, infection, varicose veins, pregnancy, hemiplegia, cancer, and a small idiopathic group.[1]

Besides being the most frequent primary disease associated with phlebitis, cardiac disease is an associated factor in most of the other cases. Not only are cardiac patients more predisposed to phlebitis, but they are less able to withstand the embolism which may occur. Approximately 73 per cent of the fatal pulmonary emboli were associated with heart disease.

The hemiplegic cases require special note, since most of the fatal pulmonary emboli were unsuspected. The majority of the hemiplegic cases were either holding their own or improving when they died of the pulmonary embolism. This is mentioned solely to deter a pessimistic attitude toward the hemiplegic. A large percentage of these people will go on living many fruitful years. Whenever a physician treating a hemiplegic patient discovers that the paralyzed leg becomes swollen or exhibits varicose veins or other signs of the phlebitic syndrome, he should actively treat this disease to prevent embolism.

Migratory phlebitis was seen in a few of the cancer patients in this series. We are well aware of the association of this disease with Buerger's disease. Too often, its association with carcinoma is not thought of.

In order to prevent phlebitis various measures must be taken to combat some of the factors mentioned in the second paragraph. The most useful measures are compression bandages on the legs, continuous ambulation, and elevation of the legs of bedridden patients. Continuous ambulation should be emphasized in surgical patients because too often a patient is bedridden before surgery and then is immediately ambulated the day after surgery. Preoperative as well as postoperative ambulation should be the rule.

Despite all prophylactic measures phlebitis, with its attendant pulmonary embolism, will occur. I firmly believe that the best prevention against pulmonary embolism *is the early diagnosis and prompt treatment of phlebitis.* The lower extremities of all patients confined to a hospital should be checked daily by the physician in order to elicit any calf discomfort or any other evidence of phlebitis. Physical examination may elicit any of the following signs: calf tenderness, edema, tenderness along the popliteal or femoral veins, positive Homans sign, distended veins in the involved extremity, arterial spasm, or cyanosis. The presence of superficial phlebitis in any patient, particularly the elderly,

*Presented at the Reunion Day of the St. Joseph's Hospital Staff Association, Providence, Rhode Island, September 7, 1955.

should always arouse a suspicion of an underlying deep phlebitis.

The nursing staff should also be alerted to the possibility of phlebitis and should aid in the detection of this disease. The nurses are more closely associated with the patient than the physician. They see them hourly on the wards and are more apt to be informed of any slight calf discomfort than is the physician. Physicians teaching nurses should emphasize this particular point.

As soon as the diagnosis is made, phlebitis should be treated by whatever measure the physician considers of value. One should never wait for a pulmonary embolism to occur before treatment, since at the Boston City Hospital the first embolus was fatal in over 80 per cent of the cases.

There is much discussion as to whether phlebothrombosis and thrombophlebitis are separate processes. It is often thought that phlebothrombosis with minimal signs has a high rate of pulmonary embolism, and that thrombophlebitis with its more obvious pain, tenderness, and edema is associated with a low rate of pulmonary embolism. This often lulls a physician into a false sense of security when treating so-called thrombophlebitis. At the Boston City Hospital there was such a high rate of embolism with the two processes that both should be treated as actively as possible.

Today, there are two ways of preventing pulmonary embolism in phlebitic patients: the administration of anticoagulants or proximal venous interruption. Anticoagulant therapy consists of prescribing heparin for the first several days until Dicumarol or Danilone are giving satisfactory blood levels. The clotting time for heparin therapy should be approximately thirty minutes, and a prothrombin time of thirty to forty seconds should be maintained with Dicumarol or Danilone.

The usual contra-indications to anticoagulant therapy are failure of such therapy to prevent emboli, recent postoperative cases, cerebral hemorrhage, recent post-partum cases, hepatic or renal disease, bleeding diatheses, subacute bacterial endocarditis, and large ulcerating areas. In addition to these contra-indications there are definite theoretical disadvantages to anticoagulant therapy. In the first place, one cannot get as quick a protection as with surgical division. Several of our patients died within twenty-four hours of admission before proper blood levels could be obtained. Secondly, it is a well-known fact that in spite of adequate prothrombin or clotting time levels, fatal emboli have occurred. Thirdly, one is never sure when to stop anticoagulant therapy. Several of our fatal cases occurred after the anticoagulant therapy had been omitted.

There are definite hemorrhagic complications of anticoagulant therapy. Sloughing areas associated with hematomas are time-consuming and add weeks or months to a patient's hospitalization. Some of the hemorrhages have been fatal.

The mortality rate for a small series of cases treated with anticoagulant therapy at the Boston City Hospital was 29 per cent as compared to a mortality rate with no treatment of 37 per cent in a larger series of cases

In contra-distinction to the above-mentioned high mortality rates, surgical treatment demonstrated a rate of only 2.1 per cent. Although surgery gave by far the best results in preventing emboli, some failures occurred. By analyzing these as well as reviewing the successful experiences, the following scheme of treatment has evolved:

Surgical division of the superficial femoral veins should be done when the phlebitis is confined to the calf veins. Division, rather than ligation, is emphasized since we have had cases which have recanalized and thrown off fatal emboli after ligation. Following the femoral division compression bandages should be applied to the legs, and the patient should be ambulated as soon as possible. Following bilateral superficial femoral division, if signs of phlebitis occur proximal to the division, vena cava division or anticoagulant therapy is needed. The choice will depend upon the condition of the patient.

A division of the common femoral vein should be performed if there is evidence that phlebitis is present in the thigh veins. Signs of this would be tenderness along the femoral veins, edema in the thigh, obvious disease in the deep femoral system at the time of surgery, or in phlebitis accompanying fractured femurs when it can be assumed that there is disease in the thigh veins. These cases should have Ace bandages and early ambulation following surgery. The possibility of the phlebitis spreading proximally should be carefully noted so that further therapy can be instituted.

During division of either the superficial or common femoral veins, if the blood clot cannot be easily removed to give a strong retrograde flow of blood, either a vena cava division or anticoagulant therapy is indicated. The chief consideration here is the physical condition of the patient, since a vena cava ligation is a serious operation and should not be contemplated on patients who are poor risks.

When phlebitis is obviously in the iliac or other pelvic veins, cava division or anticoagulation is necessary. There is one difference, however, in that bilateral ovarian vein division should accompany the vena cava ligation in women.

What is the best treatment after a pulmonary embolism has occurred? Essentially, it will depend upon the site of the phlebitis. However, the size of the embolus may be a deciding point, particularly if vena cava division is under consideration. With serious clinical or X-ray signs of pulmonary em-

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THE BEGINNINGS OF MEDICAL EDUCATION IN RHODE ISLAND

Part III

SEEBERT J. GOLDOWSKY, M.D.

(*concluded from October*, 1955, *volume* XXXVIII, *number* 10, *page* 593)

The Author. *Seebert J. Goldowsky, M.D., Surgeon, Miriam Hospital; Assistant Surgeon, Rhode Island Hospital, Providence, Rhode Island.*

WITH THE CLOSING of Brown University Medical School the first two centuries had almost come to a close. The beginning of the modern era began some forty years later with the opening of Rhode Island Hospital. We shall retrace our steps with a quick survey of the growth and development of hospital practice in the state, culminating in that important event. The earliest hospitals were of three general categories: military; marine, for the care of sick merchant seamen; and quarantine, for isolating patients with such diseases as smallpox and yellow fever. There appears to have been an overlapping of functions in the latter two types. The buildings provided were usually of modest proportions and were frequently merely private homes requisitioned for hospital purposes. Newport established a smallpox hospital on Coaster's Harbor Island in 1716, while Bristol procured a house for the same purpose as early as 1732. In 1792 an older quarantine building in Newport was rejuvenated as a smallpox hospital.

During 1777 a military general hospital was established at Tiverton for the handling of casualties expected in the local operation against the British, known in history as the Battle of Rhode Island. In 1789 a United States Marine Hospital was established at Newport, but this had a brief career, having been discontinued before 1802, according to official government reports. There is some evidence, however, that this facility operated much longer, inasmuch as Doctor David King of Newport wrote in 1859 that Doctor Edmund Thomas Waring served for some thirty years as "Physician of the United States Marine Hospital . . . thus occupying a post which the extensive commerce of Newport rendered both lucrative and important."

Early Providence Hospitals

Between 1752 and 1776 the Town of Providence provided three smallpox hospitals, the first two being in North Providence and at Tockwotton. The third, built in 1776, was in the general vicinity of the present city yards on Henderson Street. In 1798 at the height of the yellow fever epidemic of that year, the town built a new hospital on the west side of the river near the site of the one last mentioned, for the reception of patients with that disease. A bill for labor and materials still extant among the old town papers designates this building as the "new hospital," and maps subsequent to this period for the next two or three decades designated these buildings as the "old hospital" and the "new hospital." Just when the latter acquired the designation of the "Marine Hospital" is not clear. At any rate it is important to us so identified as it still stands and provides a link with the past. It stood originally on the present location of the old Rhode Island Hospital (soon to be torn down). Upon the building of that structure it was moved to its present site near the Lockwood Street entrance and still serves as the employment office. The porch was not part of the original edifice. We have noted earlier that Doctor Levi Wheaton served it as physician for many years and probably used the clinical material for teaching purposes. In 1900 on the occasion of the opening of a new pavilion at the Rhode Island Hospital, Doctor J. W. C. Ely, the only surviving member of the original staff, pro-



Fig. 7. The "New Hospital," also referred to as the Marine Hospital, before removal to its present site on the grounds of the Rhode Island Hospital, where it is presently used as the employment office. ***(Reproduced from Fields "State of Rhode Island and Providence Plantations," 1902)***

vided the following reminiscence: "On it stood a long, low two story building, used by the city for contagious diseases, especially ship fever and smallpox. During the fifteen and one half years of service as city physician, I gained most of what clinical knowledge I have of small-pox and typhus fever in that building." It was last used for patients during the Civil War. In the summer of 1862 Governor Sprague requisitioned it to provide shelter and food for invalid and wounded soldiers passing through Providence on their way home to other states. It was closed after one year, having received during its period of operation 750 casualties, "embracing many wasting away under disease engendered by the exposure of the field, or suffering severely from wounds."

We have noted earlier that the city acquired property at Field's Point in 1824 for the establishment of a smallpox hospital. A sentinel was kept on the Point to flag down ships for quarantine purposes, as provided in town quarantine regulations. This facility was maintained on a stand-by basis, although rarely used, until the Providence City Hospital for contagious diseases, later the Charles V. Chapin Hospital, was opened in 1909. A photograph of the old building published in 1902 revealed it to be hardly more than a hut.



Fig. 8. The Smallpox Hospital at Field's Point. ***(Reproduced from Fields "State of Rhode Island and Providence Plantations," 1902)***

In 1829, one year after the building of the Arcade and the opening of the ill-fated Blackstone Canal, the benefactors of the community incorporated the Providence Dispensary to provide medical care and medicines to the indigent residents of the city on a home care basis. The dispensary had no beds. It disappeared from the scene around the turn of the century.

Mrs. Anne Royal of the City of Washington, writing in her "Sketches of History, Life and Manners in the United States," made the following observations about Providence in 1826: "Providence is a very romantic town, lying partly on two hills and partly on a narrow plain, about wide enough for two streets. . . . It contains 14 houses for public worship, a college, a jail, a theater, a market-house, 8 banks, an alms-house, part of which is a hospital, and 12,800 inhabitants [a fairly accurate estimate]. The churches are very splendid, and the jail is tolerable, but the poor-house does not deserve the name, and the hospital is a wretched abode, disgraceful to the town. . . . The poor-house is in an old building in the most unwholesome part of the town. There were about twenty paupers in it, the dirtiest set of beings I ever saw. I found five maniacs in the hospital, lying on straw upon the floor, which looked as though it had not been swept or washed for years. The citizens, however, are engaged in measures to render these establishments more comfortable."

Among these measures, whether or not she was aware of it, was the bequest by Ebenezer Knight Dexter upon his death in 1824 of $60,000 (a sizable sum for that period) for the benefit of the poor people of the town. Plans were undertaken in 1826 to build an asylum in accordance with the provisions of the will. Although the edifice was not completed until 1830, occupancy began in 1828 with 64 paupers, increasing gradually to a census of 125 in 1895. For some twenty years until the opening of Butler Hospital it also provided shelter for the insane, one quarter of its inmates at times belonging to that category. According to Doctor George V. Hersey it was the only maternity home in Rhode Island before the opening of the Providence Lying-In Hospital in 1884, "and many children have been born beneath its sheltering roof." Pending some final litigation its days now appear to be numbered.

The first major medical institution in the city resulted from a bequest of $30,000 in 1841 by Nicholas Brown for the erection and endowment of a retreat for the insane. This was followed by other gifts, the largest amounting to $40,000 by Cyrus Butler after whom the institution was to be named. Chartered in 1844 it received its first patients in 1847. It began operations under the direction of Doctor Isaac Ray, the first of a line of distinguished superintendents. After a long career, during which it had acquired an international reputation, it has but recently closed its doors.

Another military medical establishment warrants our attention. In 1862 under the supervision of the War Department a general hospital was activated at Portsmouth Grove, a locality in the town of Portsmouth, Rhode Island. This obviously was a major undertaking. Its first allotment of patients, 1724 in number, arrived on July 6th of that year. The installation comprised 58 buildings, including 28 for wards and 30 for mess hall, kitchens, laundry, stores, dispensary, commissary, enlisted and officers' quarters, blacksmith and carpenter shops and other service facilities. It provided a chapel, auditorium and library. Through August 1, 1863,

continued on next page

the first year of its operation, it received 6,866 patients, of whom 101 were to be buried in the attached cemetery. At some point it acquired the name Lovell General Hospital, a somewhat nostalgic one to a later generation of Rhode Island servicemen and physicians. Its first commanding officer was Doctor Francis L. Wheaton, son of Doctor Levi Wheaton, a graduate of Brown University Medical School and surgeon in the United States Volunteers. Doctor Lewis A. Edwards, Surgeon U.S.A., who succeeded him as commanding officer, was unanimously elected on June 1, 1864, an honorary member of the Rhode Island Medical Society, attesting to the cordiality existing between the local profession and the neighboring military medical officers, a relationship which happily is still evident.

Doctors Appeal for City Hospital

On December 10, 1851, a committee of physicians headed by Doctor Usher Parsons addressed the following letter to the taxpayers of Providence:

"Sirs:

"The physicians of Providence have long felt the want of a Hospital in this City for the reception of patients who require medical and surgical treatment, and who are not otherwise provided for. They meet with such patients in their professional walks daily whilst to the public generally their great number rarely becomes known. . . .

"It is true that some patients receive aid from the Dispensary, and still more from the gratuitous services of Physicians and some few are sent to the Dexter Asylum. But there are others, badly lodged, often in garrets or cellars, without light or ventilation, and open to the storms of winter, who if honest are harassed by the idea of accumulating rent, are destitute of wholesome food and fuel, and unable to obtain good nursing. Under such circumstances a hospital for their reception, when suddenly overtaken with grave disease or severe injuries would not only supply what is needed, but would actually preserve many lives.

"Again, there are persons of good and industrious habits, who meet with sickness or injury just as they are entering into life, and who have not had time to prepare for such a calamity. . . . Such persons may fall from buildings, be wounded on railroads, or in attempts to extinguish fires in our City, who in other cities are conveyed to a good hospital to receive the best medical or surgical aid, but in Providence are carried to a crowded garret or cellar, where they prefer suffering many privations during a lingering cure, and incurring heavy expenses to be paid for by future earnings, to being carried to the Dexter Asylum, to dwell with paupers and the victims of debauchery. The Asylum, however spacious and well adapted it may have been ten years ago, is now crowded with the offscourings of Europe, and patients cannot receive proper treatment without such a change in its arrangements as would be incompatible with its ordinary or legitimate uses.

"At the present, many persons afflicted with chronic diseases, and requiring skillful operations and treatment, go from our City and State to the well-established hospitals of Boston and New York; and many others would avail themselves of that high privilege, but for want of means. These, certainly, ought to be provided for within our own State. . . .

"As an earnest of their readiness to aid in supporting a hospital, they engage to serve it gratuitously as physicians or surgeons, whenever they are required."

This communication reached every taxpayer who was assessed to pay a tax of $100 or more. The letter is interesting in several respects. It emphasized the marked impact of the recent industrial revolution on the economy and upon the way of life in the city and state. A further complicating factor was the flood tide of immigration from Europe which was having obvious effect upon the numbers of sick poor requiring attention from the local medical community. The inclination of the well-to-do to travel to neghboring large cities for treatment has a strangely familiar ring, and obviously caused the profession some chagrin. Undoubtedly, however, the plaintive reference to "that high privilege" was largely inspired by altruistic motives.

This broadside produced no immediate reaction. Consequently, in the following year a petition was presented to the city government using much of the same phraseology. The following remarks were added: "No city of the population and wealth of Providence has deferred so long a time to provide a public hospital. . . . We respectfully beg leave to recommend that a hospital be provided by the city, to be sustained by private subscriptions. . . . We hope that you will appropriate . . . some . . . suitable place for a hospital, on condition that fifty thousand dollars be raised by private subscription." The City government in answer to this request appointed a committee to meet with the physicians to examine the facts. There followed considerable further delay during which the relative merits of the Tockwotton estate and the "od hospital lot" were weighed.

Moses Brown Ives, who died in 1857, left $50,000 in trust for public benefactions. After otherwise disposing of some $10,000, the trustees were finally persuaded in 1863 to make the remain-

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The RHODE ISLAND MEDICAL JOURNAL

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MEDICAL EDUCATION

In the September number of the JOURNAL Doctor Seebert J. Goldowsky presented the first of three papers on the history of medicine in Rhode Island. We have a feeling that the modern doctor should have a little more background than he seems usually desirous of obtaining. It would save a lot of trouble. One of the much advertised modern pieces of impedimenta was essentially developed six hundred years before Christ and promptly forgotten.

From its beginning when Doctor William Hunter, a cousin of the famous eighteenth century Hunter Brothers of England, started practicing in Newport, Rhode Island has had a most excellent medical history. Doctor Benjamin Waterhouse, of Newport, gave us a lot of good information about the early physicians. He, appointed in 1782 Professor of the Theory and Practice of Physic at The Harvard Medical School, was, despite his failings, a great physician who was responsible for the introduction of smallpox vaccination in America. Doctor Usher Parsons, Naval hero surgeon of the Battle of Lake Erie, and Doctor Solomon Drowne, who developed his most interesting botanical garden at Mount Hygeia in Foster, were brilliant members of the ill-fated Brown Medical School. More of that caliber were not uncommon in Rhode Island's medical history. We feel that we are fortunate in having this careful and interesting story brought to us by Doctor Goldowsky, and we trust that you will all do yourself a lot of good by reading it.

TELEPHONE LISTINGS

The action of the House of Delegates in clarifying the local situation regarding telephone and other directory listings is published elsewhere in this issue (see House of Delegates, Committee on Public Relations, page 647). The question of how specialties should be publicized, and to what extent, has been subject to review by many medical societies throughout the country during the past year. Twice our Society made rulings on the matter, and in neither instance was the issue completely resolved.

The current action of the House of Delegates is based on a comprehensive study by the Society's committee on public policy and relations that included a report on the entire problem of so-called physician advertising.

The adoption of these new regulations should be recognized as an effort to assist the public primarily, particularly in view of the increasing number of physicians who now enter medical practice limiting their work to a restricted field of service.

All directory listings must be limited by the specialty classifications posted by the Society in its annual roster (see October issue of the R. I. MEDICAL JOURNAL), and they are subject in addition to final approval by the committee on public policy and information.

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The House rulings on newspaper announcements, office signs, and program displays merely establish as written regulations the procedures that have been generally recognized by most physicians through the years.

THE DOCTOR MICHAEL H. SULLIVAN SCHOOL

Late last August the people of the city of Newport joined with their school committee for the dedication of one of the newest schools in the state —an elementary school that will also serve as a training school for students of Salve Regina College who are entering the teaching profession—in the name of Dr. Michael H. Sullivan, dean of the active physicians of Rhode Island, and a past president of our Society.

For fifty-four years Doctor Sullivan has engaged in the general practice of medicine, and for more than fifty of those years he has been chief of obstetrics at Newport General hospital. In 1953 he was cited by our Society as the "Practitioner of the Year," and he was lauded by the General Assembly and the City Council of his own city. And when the laudatory speeches had been said, the tributes paid, and the awards given, Doctor Sullivan resumed the daily rounds of his medical practice unchanged not the least by it all.

And now a living memorial has been created for one of the most beloved physicians in the state, and we suspect that it is the kind of a memorial that Doctor Sullivan likes best, for he has been the physician at hand for more than 15,000 births in his Newport area, and he has watched his thousands of children grow up. Doctor Sullivan cannot be eulogized adequately in type, as his hometown newspaper pointedly stated in 1953 when it remarked "print cannot reveal the gratitude people feel for the man who has been physician and friend and counselor and helper, so how can you write an editorial about a man whose greatest editorial is written in the hearts of the people of the city he has loved and that loves him."

But Newport has found an admirable public expression for her favorite physician, and the handsome half million dollar building near the Middletown boundary line will be a fitting tribute to a truly remarkable man.

CARE OF EXPERIMENTAL ANIMALS

We get many a request to announce meetings and we have to let most of them, which are not particularly pertinent to our particular organization, go by unnoticed. However, we are pleased to announce the forthcoming meeting of the Animal Care Panel on December 1st and 2d, at the Henry Hudson Hotel (353 West 57th Street), New York City.

The Animal Care Panel is an organization of investigators, administrators of animal quarters, animal breeders, food and cage manufacturers; in short, individuals interested in the care of experimental animals. The program will consist of papers dealing with the physiology and behavior of laboratory animals, their diseases, nutrition and related problems.

The anti-vivisectionists have striven hard to make the public believe that we seize any stray animals which we may find and torture them chiefly because of our sadistic leanings. We do not believe that any intelligent people really believe this, but constant reiteration may fool the public. Of course, there is no truth in this. First of all, most of the animals used in experiments have pedigrees that would make the Kings of England look like upstarts. When any of these experiments are started, it is a pretty miserable thing to lose any of these important animals. Therefore, we presume that no human beings get the perfect care that these animals get. We doubt if any of you go down to New York, but we should emphasize the extreme care these animals are getting.



Daily News Photo

DOCTOR MICHAEL H. SULLIVAN SCHOOL IN NEWPORT, RHODE ISLAND

TO ALL MY PATIENTS

The new A.M.A. pamphlet, titled *To All My Patients* has been distributed to all members of the Association. It is a fine public relations aid to your medical practice that should be made available to your patients.

The attractive twelve-page pamphlet describes briefly the responsibilities of various persons on the medical team, it discusses medical fees and health insurance, and it encourages a friendly discussion of medical services and the fees charged for them.

We know that physicians find their mail padded with literally hundreds of brochures, pamphlets, and leaflets emanating from many sources, and all for the most part seeking to sell the doctor some product or service. The pamphlet *To All My Patients* should be read by every doctor, and copies should be ordered from the A.M.A., or through the state society executive office, for distribution to your patients. The pamphlet may be left on waiting room tables, or it may be mailed by you to your patients since space has been provided on the back cover for you to imprint your name, or a mailing address.

Here is a fine new approach to help you and your patients achieve that mutual undestanding so important to a successful doctor-patient relationship!

FUNDS FOR MEDICAL EDUCATION

The medical profession pledged two million dollars annually in 1951 to assist the nation's medical schools, and through the efforts of the American Medical Education Foundation more than one million of that fund has been subscribed in each of the past two years.

Recently every physician received a special appeal signed by Doctor Hess, president of the American Medical Association, urging continued support of the program. The record shows that Rhode Island physicians have contributed liberally to medical school aid in recent years, although the bulk of such contributions has been through direct mailings to the schools rather than through the AMEF.

Several state medical societies, including our neighbor, Massachusetts, have contributed gifts from their society treasury to aid the campaign. Some states have made special assessments for the same purpose. We have not felt that a special tax is necessary upon our membership, and the record indicates to the contrary that Rhode Island physicians individually have supported medical education through voluntary contributions to their respective schools.

But the situation in 1955 calls for increased individual assistance to maintain our high medical teaching standards without Federal subsidies, as has been advocated in some quarters. We are encouraged by the active support that industry has given in recent years to further interest in college and professional school training. We believe that this spirit of cooperation should be strengthened, and the best way to strengthen it would be for higher individual donations by physicians to set the example for giving by others.

E. P. ANTHONY, INC.

Druggists

Wilbur E. Johnston **Raymond E. Johnston**

178 ANGELL STREET
PROVIDENCE, R. I.
GAspee 1-2512

NEW "LONG TERM" DISABILITY INSURANCE ENROLLMENT PERIOD

for

R. I. Medical Society members

has been extended for those who are acceptable *individually*.

Members under age 61, in active practice and with good health history are *still* eligible to enroll!

Applications and information will be supplied, upon request, by:

R. A. Derosier Agency
Administrators
32 Custom House Street
Providence 3, Rhode Island
GAspee 1-1391

BEGINNINGS OF MEDICAL EDUCATION IN R. I.

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ing $40,000 available for hospital purposes. To this was added $10,000 by his son, Captain Thomas Poynton Ives. Thereupon the legislature granted a suitable charter and the City of Providence appropriated the site of the old Marine Hospital, popularly referred to as "Hospital Park." Upon issuance of the charter the list of corporators, which had previously contained the names of doctors exclusively, was enlarged by the addition of two hundred names, "mostly non-professional gentlemen." A highly successful subscription campaign followed, to which Doctor Parsons himself contributed one thousand dollars.

Medical Society Action

At its annual meeting on June 3, 1863, the Rhode Island Medical Society passed the following resolution: "That this society view with the deepest interest the successful progress of the movement for the foundation of a Rhode Island Hospital,—a movement which began with the medical profession of the City of Providence, but has now been enlarged to embrace the whole state within the scope of its beneficent operations; and we promise the corporators of the hospital all the aid and influence we can furnish in its behalf, as physicians and citizens."

This was followed by the submission to the Society of a request for a "committee with whom the committee on plans of this board may consult with regard to the construction and arrangements of the hospital buildings." The Society acknowledged this request and appointed such a committee on December 16, 1863. On June 1, 1864, at the annual meeting, it was reported that this group had submitted to the committee on plans "a detailed report in writing."

Rhode Island Hospital Opened

It is not germaine to the title of this paper to go further into the plans and building of the new hospital. Suffice it to say that no pains or expense were spared to provide the community with the most modern institution that the technology of the period could provide. The exercises celebrating the opening of the new and imposing edifice took place on October 1, 1868. The following are excerpts from the remarks of Professor William Gammell of Brown, the orator upon that impressive occasion:

"The need of a General Hospital for the sick and the injured in the midst of a population so largely employed in the mechanical arts, was first urged upon public attention in this city by the gentlemen of the medical profession, who, better than any others, know how much life was lost, because there was no such institution here. In October 1851, the Providence Medical Association appointed a committee of their fraternity to consider the subject, and to report a mode in which it might most effectually be brought to the consideration of the public. This was done at the instance of their President, Dr. Usher Parsons, our venerable friend, who today beholds the full accomplishment of all his benevolent plans."

He referred to the grounds as "this beautiful and salubrious site, which for three-quarters of a century [i.e. since 1789] had been used by the people of Providence for hospital purposes." He stated further: "A hospital must take the lead in all medical departments. Its essential work should be thoroughly done, or it should not be attempted. It has, therefore, been the aspiration of this corporation to have a hospital building that is fully equal to the highest standard of the age and as nearly perfect as can be built. . . .

"The hospitals of Philadelphia, New York and Boston, have made those cities centers of medical education for nearly the whole country. And with the aid of the Rhode Island Hospital, why may we not have a Rhode Island Medical School again associated with our own University, as there used to be some forty years ago. Indeed even without any formal establishment for the purpose, the Hospital will be, in itself, a school of practical medicine of the greatest importance to the profession. It will concentrate a knowledge of every form of disease; it will bring together the results of varied experience; it will stimulate ingenuity, and suggest improvements and discoveries." These were indeed prophetic words.

At the annual meeting of the hospital on November 10, 1868, the president, Robert H. Ives, reported: "On Tuesday, the 6th of October, the Hospital received its first patient. It was a case requiring a very severe surgical operation, which was successfully performed on the following Saturday, by the Visiting Surgeon in attendance, Dr. Mason, and in the presence of the Consulting Surgeons, who were summoned from all parts of the State. The patient is favorably progressing toward recovery." This apparently was quite an event.*

*This patient was a 59-year-old shoemaker named John Sutherland presenting necrosis of the upper jaw. Disease of the antrum was suspected. The maxilla was resected and the antrum was cleaned out. The specimen was examined microscopically (presumably without staining) and the impression of malignancy was confirmed. The patient made an uneventful convalescence and was discharged on December 7, two months following admission. We could not do much better today.

The second surgical admission was a 55-year-old Irish servant who was treated for a varicose ulcer with bed rest and wet dressings. She was discharged healed after three months.

The first medical admission was a 49-year-old German gunsmith presenting "articular rheumatism." He was discharged after five weeks unimproved. These cases have a hauntingly familiar sound.

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MICTINE*—THE NEW ORAL DIURETIC

Searle MICTINE Provides Effective Oral, Non-Mercurial Diuresis

The result of many years of research, Mictine, brand of aminometramide, supplies a long-felt need for an improved oral diuretic. Mictine, 1-allyl-3-ethyl-6-aminotetrahydropyrimidinedione, is not a mercurial, xanthine or sulfonamide.

Effectiveness: Every method for measuring the diuretic effect in man now available, including precise human bioassay studies, without exception demonstrated that Mictine is an effective oral diuretic, and these studies show that approximately 70 per cent of *unselected* edematous patients treated with Mictine by mouth respond with a satisfactory diuresis.



Mictine is believed to act by the selective inhibition of the reabsorption of sodium ions. Thus, the resulting diuresis is characterized by increased quantities of sodium ions and water.

Well-Tolerated: There are no known contraindications to Mictine, even in the presence of hepatic or renal damage, and there is no risk of acidosis. On high dosage, Mictine causes some side effects in some patients but on three tablets daily these side effects (anorexia and nausea, rarely vomiting, diarrhea or headache) are minimal or absent.

Indications: Mictine is useful primarily in the *maintenance* of an edema-free state and in the *initial and continuing* control of patients in mild congestive failure. Mictine may be used also for *initial and continuing* diuresis in *more severe* congestive states, particularly when mercurial diuretics are contraindicated.

Administration: The usual dosage for the average patient is one to four tablets daily with meals, in divided doses on an interrupted schedule. An interrupted dosage schedule may be accomplished by giving the drug on alternate days or for three consecutive days and then omitting it for four days.

For severe congestive states the dosage is four to six tablets daily with meals, in divided doses on interrupted schedules similar to those already mentioned.

Supplied: Uncoated tablets of 200 mg.

**Trademark of G. D. Searle & Co.*

SEARLE

BEGINNINGS OF MEDICAL EDUCATION IN R. I.

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Hospital Library Developed

The plans for the new hospital provided space for a library and for a lecture room. In the annual report of November 9, 1864, appears the following statement: "The Library of the late Dr. Ezekiel Fowler, of Woonsocket, in this State, bequeathed by him to the Rhode Island Hospital, has been received, and is now in the custody of the Board. The Library consists of about four hundred volumes of medical, surgical, biographical and miscellaneous works. It will serve as a timely and valuable commencement of a Hospital Library, which it is hoped will continue to receive accessions by donations from other friends of the Institution." Here is good evidence that the trustees were deeply interested in the problem of education even before the new hospital opened its doors. In the annual report of November 13, 1867, the bequest of one hundred volumes "of the more recent standard works" from the library of the late Doctor J. Davis Jones was announced. He had died prematurely at the age of twenty-eight. This donation was "highly appreciated as the gift of a young man who understood its importance to the Medical and Surgical Departments of the Hospital. . . . We earnestly commend to public notice this instance of thoughtful liberality at the commencement of our active operations as a Hospital. The large and beautiful room designed for the library and the museum, will be ready for occupancy in the course of a few weeks. Valuable books, specimens of morbid Anatomy, well executed Anatomical drawings and models, Pathological specimens and like means of illustrations will be timely and most acceptable presents, and will add largely to the usefulness of the Institution."

Additional gifts of books at the time of the opening of the hospital brought the total to some 1400 volumes, including 300 from the library of Doctor Usher Parsons. One contribution included "upwards of three hundred volumes, mostly in the French language, and a black walnut case for the same" and another "a cabinet of very choice pathological specimens."

On December 16, 1868, shortly after the hospital had started operations, the Rhode Island Medical Society voted: "That all books, instruments and apparatus belonging to the Society, and now in the hands of the Cabinet Keepers, and Librarians: also, any preparations belonging to the Society, be, and they hereby are, presented to the Rhode Island Hospital; provided, the members of this Society shall be permitted to have free use of them when desired, subject to the rules of the hospital." This contribution included the original gift of 72 volumes from the library of Doctor Caleb Fiske. By 1874 the hospital librarian, Doctor Charles L. Leonard, was able to report that the library had increased to 2000 volumes. The fate of this historically valuable collection is an unhappy one. Some time during the year 1930, prior to the opening of Peters House, the new residence building for interns and residents, Doctor John M. Peters, then superintendent of Rhode Island Hospital, felt the need of disposing of the outmoded books in order to provide additional space for other hospital services. Unfortunately he appears to have been rather unsentimental with respect to the historical value of old books and prepared forthwith to sell them for waste paper. A few discerning individuals salvaged some of the more valuable specimens. The rest of the library was scattered. The Rhode Island Medical Society to which many rightfully belonged appears to have been left out.

One other note is of interest. In the Annual Report of November 10, 1869, appeared the following ruling: "The Trustees may grant any practitioner or student of medicine, of one year's standing, a ticket of admission to follow the practice of the Hospital for not more than one year."

Doctor Usher Parsons, a surviving link with an earlier excursion into medical education, lived to see his dream realized. He was able to attend the opening exercises of the hospital on October 1, 1868. Wrote his son, Professor Charles W. Parsons: "He was conducted to a seat on the platform, and was kindly referred to in Professor Gammell's eloquent discourse [see above]. This compliment, the last he was ever to receive on any public occasion, gratified him very much. He wrote in his diary the next day, with a trembling hand, 'I feel very happy for yesterday's doings.' He was present at the first important surgical operation performed there, October 10 [as Chief of Consultants]." His death occurred two months later.

Medical School Hopes Revived

The hope expressed by Professor Gammell that Rhode Island might yet see another medical school was to linger on. Wrote Professor Parsons in 1881 in his history of Brown University Medical School: "There has been no medical department in this institution since the advent of President Wayland, and for almost fifty years there was no medical man on the Faculty. . . . Whether a medical school will ever be revived here, is a question not of history, but of very doubtful forecast. Providence, from a town of 15,000 inhabitants, has grown into a city of more than 100,000. It contains a Hospital and Dispensary, both furnishing opportunities for clinical instruction far surpassing any that the Professor of Theory and Practice of Medicine could command in Dr. Messer's time. The University has for several years shown great hospitality to those physical sciences which are tributary to the medical art, . . . zoology, botany, chemistry and

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HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting, September 28, 1955

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, September 28, 1955. The meeting was called to order by the president, Frank B. Cutts, M.D., at 8:15 P.M. The following delegates were in attendance:

KENT COUNTY: Edmund C. Hackman, M.D.; Russell P. Hager, M.D. *NEWPORT COUNTY:* Henry W. Brownell, M.D. *PAWTUCKET DISTRICT:* Robert C. Hayes, M.D.; Henry E. Turner, M.D.; Harold A. Woodcome, M.D.; Hrad H. Zolmian, M.D. *WASHINGTON COUNTY:* James A. McGrath, M.D. *PROVIDENCE MEDICAL:* Charles J. Ashworth, M.D.; Irving A. Beck, M.D.; Alex M. Burgess, Jr., M.D.; Wilfred I. Carney, M.D.; William B. Cohen, M.D.; Edmund B. Curran, M.D.; John A. Dillon, M.D.; Michael DiMaio, M.D.; William J. H. Fischer, Jr., M.D.; John C. Ham, M.D.; Hannibal Hamlin, M.D.; William S. Nerone, M.D.; Arnold Porter, M.D.; Louis A. Sage, M.D.; Lee G. Sannella, M.D.; William J. Schwab, M.D.; George W. Waterman, M.D. *OFFICERS OF THE RIMS (other than delegates):* Frank B. Cutts, M.D.; Thomas Perry, Jr., M.D.; John G. Walsh, M.D. *IMMEDIATE PAST PRESIDENT OF THE R. I. MEDICAL SOCIETY (without vote):* Henri E. Gauthier, M.D. *WOONSOCKET DISTRICT:* Francis P. Vose, M.D.

Also in attendance were Doctors John T. Barrett, chairman of the Child and School Health Relations Committee; David Freedman, trustee of the Benevolence Fund; Earl J. Mara, chairman of the Social Welfare Committee; Francis B. Sargent, chairman of the Group Liability Insurance Committee; and John E. Farrell, Sc.D., Executive Secretary.

REPORT OF THE CHILD AND SCHOOL HEALTH RELATIONS COMMITTEE

Dr. John T. Barrett, chairman of the Child and School Health Relations Committee, reported on the status of the distribution of polio vaccine in Rhode Island. He related the development of the State Advisory Committee, and he briefly reviewed the meetings held by this Committee. He indicated that in view of the federal regulations restricting the use of the vaccine received by the state on a matching fund basis, the Committee had accepted the ruling that children in the age group, 5 to 9, should receive first priority, then the age group, 1 to 5, after which pregnant women and other adults would be eligible. He stated that $135,000 had been allocated to the state of Rhode Island to be used prior to next June, and this amount would purchase approximately 150,000 cc. of the vaccine. No means test is to be included in the distribution which is to be carried out in clinics established by the State Department of Health. Dr. Barrett stated that the small quantity of vaccine available at the present time forced the decision to handle all of it presently through the public agencies.

Action: The report was discussed briefly by the members of the House after which the sentiment of the House was expressed that the Child and School Health Relations Committee should issue any statement necessary regarding the distribution of the polio vaccine in Rhode Island for publication in the RHODE ISLAND MEDICAL JOURNAL for the information of the members.

MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the House of Delegates, distributed in mimeographed form to each member and subsequently published in the RHODE ISLAND MEDICAL JOURNAL, were approved for permanent file.

REPORT OF THE SECRETARY

Dr. Thomas Perry, Jr., secretary of the Society, submitted the following report:

The council has held one meeting since the last meeting of the House of Delegates. Among matters resolved were the following:

1. The report of the trustees of the Caleb Fiske Fund was received relative to the 1955 prize dissertation, and approved.
2. The Council was notified that the request of the Society to the American Medical Association that AMA dues be assessed directly from its Chicago headquarters office would entail a bylaw change for the Association not contemplated at this time.
3. Dr. Francis V. Corrigan, Chief of the Division of Maternal and Child Health of the

continued on page 644

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HOUSE OF DELEGATES

continued from page 642

Rhode Island State Department of Health, was designated to represent the Society at the Fifth National Conference on Physicians and Schools to be held at Highland Park, Illinois, in October, if he finds it possible to attend the meeting.

4. Dr. Charles J. Ashworth, Chairman of the Society's Committee on Federal Medical Services, and the Executive Secretary were designated as official delegates of the Society to a regional legislative conference under the auspices of the American Medical Association to be held in New York City on October 29 and 30.
5. Dr. Walter E. Campbell, Chairman of the Society's Committee on Mental Health, was designated as the Society's official delegate to the Second National Conference of State Society Representatives to confer on mental health problems, the meeting to be held in Chicago in November.
6. A resolution adopted at the Annual Meeting of the Rhode Island Pharmaceutical Association was referred to the Society's Committee on Medical-Pharmaceutical Relations.
7. A special report from the Committee on Medical Defense and Grievance was received and placed on file.
8. The Committee on Mental Health of the Society was asked to confer with Butler Hospital authorities relative to the storage and availability to Rhode Island physicians of the medical records of the Hospital.
9. The Committees on Medical Economics and Social Welfare were asked to give consideration to a review of the Uniform Fee Schedule for Governmental Agencies first adopted in 1950.
10. The Board of Trustees were requested to secure estimates for the costs of necessary improvements to the Library building.
11. The Board of Trustees of the Library were authorized to place an appropriate marker on the lectern in the Library auditorium to indicate that it is a gift of Dr. Stanley Freedman of Providence.
12. A proposed budget for the Society for 1956, as submitted by the Treasurer, was approved.
13. The Treasurer was instructed to transfer to the Agency Account of the Society the bequest from the Estate of the Late Dr. Jesse E. Mowry for investment.
14. A committee was authorized to study recommendations made by the Chairman of the Library Committee and to report to the Council at a future date.
15. Membership of the Society in the Council of the New England State Medical Societies was renewed, and Drs. Frank B. Cutts, Charles J. Ashworth and Thomas Perry, Jr., were named as the Society's official delegates to this Council.
16. The State Director of Health was requested to recall from circulation the booklet issued recently by the Department listing a registrar of physicians in Rhode Island for the reason that it lists specialty designations which are not accurate and which should not be listed in such a publication, it has many errors, and it lists osteopathic physicians in the registrar of doctors of medicine.

Action: It was moved that the report of the Secretary be received and approved and the actions taken by the Council, as reported, be approved. The motion was seconded and adopted.

Recommendation from the Council

The Secretary reported the following recommendation from the Council:

To meet the anticipated expenses of the Society as proposed in the budget for 1956, the Council recommends that the dues in 1956 for active Fellows be $50, except that Fellows in their first year of practice shall pay dues of $25.

Action: It was moved to adopt the recommendation. The motion was seconded and adopted.

Report of the Treasurer

Dr. John A. Dillon, Treasurer of the Society, submitted the following report:

With the death this summer of the widow of Dr. Jesse E. Mowry, onetime president, and for nineteen years Treasurer of the Society, the Rhode Island Medical Society received 5% of his trust estate to be held in trust as the Jesse E. Mowry Fund, the income from which is to be used toward current expenses of the Society. The trust amounted to $6,131.54, which has been turned over to our Agency, the Industrial Trust Company, for investment in accordance with the action taken by

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the Council at its recent meeting.

The proposed budget for the Society approved by the Council is predicated on our experiences of the past few years, and it duplicates to a great extent our current budget for this year. The anticipated receipts from all sources are expected to be about $44,000 and our anticipated expenses will be approximately $42,000 with an anticipated $1800 held for a contingency fund.

The improvements to the Library building initiated last year when the annual assessment was increased primarily for that purpose, will be continued in the coming months, as the Trustees of the Library building have indicated that our property is in need of many improvements.

Action: It was moved that the report of the Treasurer be received and approved. The motion was seconded and adopted.

Communications

The Secretary reported receipt of a communication from the Pawtucket Medical Association regarding the Society's poll relative to Social Security coverage for physicians.

The Secretary read the results of the poll, as previously reported to the members of the House of Delegates individually, and he explained at length the position of the American Medical Association relative to Social Security coverage for physicians.

Committee on Group Liability Insurance

Dr. Francis B. Sargent, Chairman of the Committee on Group Liability Insurance, reported that the Society's program had enrolled 148 members, but that 43 had been rejected because of the insurance company's underwriting regulations. He discussed the problem as presented by the insurance company regarding coverage for anesthetists, radiologists and psychiatrists. He expressed the hope that the gradual development of the program would make it possible within a year to authorize coverage for every physician regardless of his specialty.

Action: It was moved that the report of the Group Liability Insurance Committee be approved as presented. The motion was seconded and adopted.

Committee on Social Welfare

Dr. Earl J. Mara, Chairman of the Committee on Social Welfare, reported that several meetings had been held of his Committee to revise the 1952 Provisions for the Purchase of Physicians' Service from the Public Assistance Funds. He reviewed many of the problems discussed and resolved by his Committee and the State Department of Social Welfare, and he called attention to the new brochure which had been issued to the membership of the Society effective September 1, 1955.

Dr. Cutts commended Dr. Mara and his Com-

continued on next page

Two Gentlemen Are Waiting to Hear From You

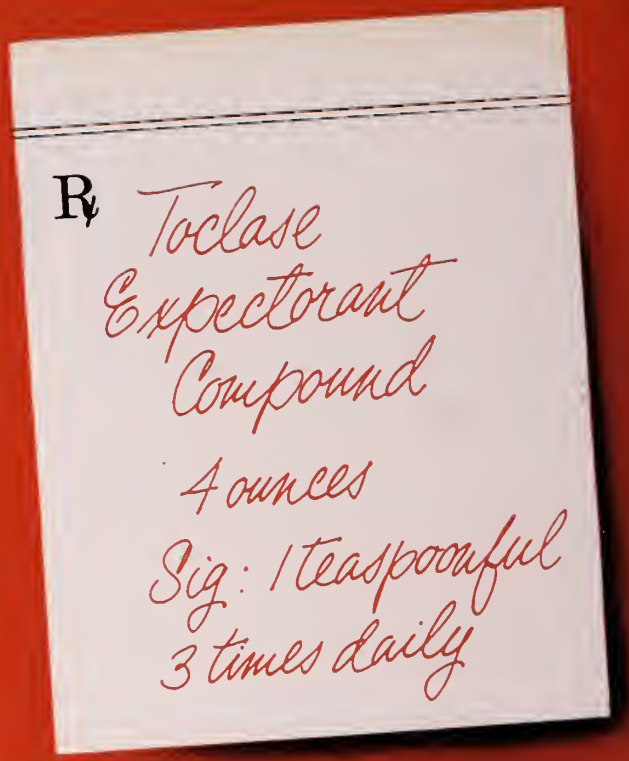
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Second, taxes. You'll want to look over your securities for possible 1955 Income Tax savings before the December 31 deadline. Here again, we can help. We'll gladly provide any security prices and market facts you need to evaluate your position and make accurate computations. No charge, no obligation, naturally. Just write, phone or stop in.

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mittee for the excellent work it has done in adjudicating problems between the profession and the State Department of Social Welfare.

Action: It was moved that the report of the Committee on Social Welfare be approved as presented. The motion was seconded and adopted.

Chemotherapy for Patients with Tuberculosis

Dr. John C. Ham submitted the following report of the meeting held on August 17th at the State Department of Health which the Medical Director of the State Division of Tuberculosis Control had requested him to present to the Society for possible endorsement. The report is as follows:

It is noted that there has been an increasing concern regarding chemotherapy for patients with tuberculosis on an out-patient basis. We have been confronted with the problem of open cases of tuberculosis refusing hospitalization on the basis that chemotherapy could be provided by private physicians outside the sanatorium. In order to obtain the best medical thought regarding this problem a meeting was called by the Director of the State Division of Tuberculosis Control in the Rhode Island Department of Health of representative physicians and social workers in this field.

Representatives of official health and welfare agencies are generally agreed that ambulatory home treatment of tuberculosis is not an ideal one. Therefore, we cannot rightfully expend State funds to encourage patients to reject the use of the excellent sanatorium facilities available in this State, and thereby continue as potential sources of infection in the community.

On the other hand, it would be unfair to withhold such treatment from deserving patients who are temperamentally unable to adapt themselves to sanatorium life. It would also be unfair to the community to treat the so-called recalcitrant patient as an outcast and deprive him of the benefits of home treatment merely because of his unwillingness to cooperate. Such treatment will, in a number of cases, bring the disease under control to the ultimate benefit of both the individual and the community.

The outcome of this meeting, therefore, was a unanimous agreement that drugs for ambulatory chemotherapy should be made available to all patients, provided certain basic requirements are satisfied; namely:

1. That the disease is reported to the Rhode Island State Department of Health.
2. That the patient is under the continuous medical supervision of a licensed physician.
3. That the patient is financially unable to purchase the needed drugs.
4. That the patient's condition is periodically reviewed at intervals of not longer than four months by the Division of Tuberculosis Control, or by an examiner approved by said Division. This particular review shall consist

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of a chest X-ray and a sputum examination as a minimum requirement.

5. That reports of this particular review by the Director of Tuberculosis Control, or by the approved examiner, be sent to the paying agency and attending physician.

Action: It was moved by the House of Delegates that the report as submitted and the recommendations incorporated therein be approved. The motion was seconded and adopted.

Report of the Committee on Public Relations

Dr. Arnold Porter, Chairman of the Committee on Public Relations, submitted the report of his Committee as follows:

At its April, 1955, meeting the House of Delegates referred to the Committee on Public Policy and Relations the recommendation it had received from the Providence Medical Association requesting that the entire problem of physician advertising, with particular reference to office display signs, telephone directory listings, newspaper displays, etc., be reviewed. This Committee was requested to report to the House of Delegates at its September meeting. Our report follows:

The question of how to list physicians' names in the classified (yellow) pages of telephone directories has been raised frequently by many medical societies. We have made three decisions in as many years on the problem in Rhode Island. It is the general rule that the responsibility for proper listing has traditionally been accepted by the physician himself or by the county medical society since local problems, customs and telephone company policies are more readily understood and, if necessary, adjusted at that level. Hence there is no universal rule in the matter, nor has the AMA taken any action.

In an effort to summarize the picture throughout the country the Public Relations Department of the AMA checked the way in which physicians' names appear in the telephone directories of 90 cities and towns in 33 states, the District of Columbia and Hawaii. A summary of the findings is attached to and made a part of this report.

Your Committee has reviewed the problem of telephone listings, and the allied issues relating to publicizing the physician's name, and it presents the following recommendations for consideration by the House of Delegates:

1. *Telephone and Other Directory Listings:* As an aid to the public specialty listings by physicians should be permitted only on the basis of specialty classification as listed by the RHODE ISLAND MEDICAL JOURNAL, and subject in addition to final approval by the Committee on Public Policy and Relations. All such specialty listings in any public directories should not be in bold type or otherwise prominent display type.

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2. *Newspaper Displays:* Newspaper displays should be permitted not to exceed two columns in width and two inches in depth, and not to exceed publication in more than six issues of each newspaper within a one-week period, to announce—
   a. The establishment of an office for the practice of medicine.
   b. To announce a change of office address.
   c. To announce resumption of practice after a term of duty with the Armed Forces of the United States, or after an absence from practice for a period of three or more months, or after a long period of illness.
3. *Office Signs:* Office signs should list only the physician's name and the abbreviation M.D., and should be consistent with local customs and precedents. Specialty listings should not be placed on office signs. Ordinary illumination of office signs is permissible for physicians having night office hours, or residing in urban or rural areas, or where off-street lighting offers poor visibility of the physician's office entrance.
4. *Display Advertisements in Programs, etc.:* The Code of Ethics provides that "solicitation of patients, directly or indirectly, by a physician is unethical." It would appear that some paid display notices in programs, such as those prepared for charity organizations and the like, are a form of indirect solicitation, when the physician's name is listed as the donor of the cost for the display. Such paid displays, in the opinion of the Committee, should not be approved. The listing of a physician as a patron in a list would be permissible.

Action: It was moved that recommendations 2, 3 and 4 be approved by the House of Delegates. The motion was seconded and adopted.

* * *

It was moved that recommendation 1 be adopted. The motion was seconded.

Discussion: There was discussion of this recommendation after which, by request of the House, the President called for a vote by a show of hands. Fourteen (14) voted "Yes" for adoption and twelve (12) voted "No." The recommendation was therefore adopted.

Physicians Service

Dr. Charles J. Ashworth, President of Physicians Service, briefly discussed the addition of X-ray benefits effective October 1, 1955. He expressed the hope that every physician would feel a sense of personal responsibility in seeing that the new benefit is not abused since the expansion of the program represents a major step for Physicians Service.

Report of the Committee on Scientific Work and Annual Meeting

Dr. Henri E. Gauthier, Chairman of this Committee, reported on the program for the Interim Meeting of the Society to be held on October 26, 1955.

He also reported on the Clinical Session of the American Medical Association to be held in Boston on November 29th to December 2nd.

Benevolence Fund

At the request of the President, the Executive Secretary briefly reviewed the history of the proposed Benevolence Fund and he submitted a new indenture drafted by the Legal Counsel.

Dr. David Freedman, one of the original Trustees of the Benevolence Fund, discussed the plans for activating a program and he submitted the following two resolutions:

Resolved: That all prior action of the House of Delegates in approving a Benevolence Fund be and hereby is rescinded, declared void and of no effect.

concluded on page 650



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HOUSE OF DELEGATES

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Resolved: That the indenture of the Benevolence Fund of the Rhode Island Medical Society substantially in the form presented to this meeting be and hereby is adopted and approved; that a copy attested by the Secretary be attached to the minutes of this meeting; that the President be and hereby is authorized to execute and deliver a copy of the indenture of the Benevolence Fund to the Trustees thereof; and that the following be and hereby are elected Trustees of said Benevolence Fund to hold office for said terms and until their successors are duly qualified and elected: Dr. David Freedman, 3 years; Dr. George W. Waterman, 2 years; and Dr. Henry J. Hanley, 1 year.

Action: It was moved that the recommendations relative to the Benevolence Fund be adopted. The motion was seconded and adopted.

* * *

The meeting adjourned at 10:12 p.m.

Respectfully submitted,

THOMAS PERRY, JR., M.D., *Secretary*

BEGINNINGS OF MEDICAL EDUCATION IN R. I.

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physiology. Its liberal spirit gives assurance that it would welcome the addition of a medical school to its other departments, if the community and the profession should be ready to demand it. . . . Whether this city, the second in New England, shall become the seat of such a school must depend very much on the zeal, persistence and ability of its physicians."

This was not the last. On a visit to Providence in 1899 William Osler delivered the following remarks before the Rhode Island Medical Society: "The existing conditions in Providence are singularly favorable for a small first-class school. Here are college laboratories of physics, chemistry and biology, and modern hospitals with three hundred beds. What is lacking? Neither zeal, persistence nor ability on the part of the physicians, but a generous donation to the University of a million dollars with which to equip and endow laboratories of anatomy, physiology, pathology and hygiene. These alone are lacking; the money should be the least difficult thing to get in this plutocratic town. The day has come for small medical schools in university towns with good clinical facilities."

Evidently the plutocrats failed to take the bait. In 1955 we have an abundance of medical education, but still no medical school.

ACKNOWLEGMENT.—I wish to express my sincere appreciation to Mrs. Helen DeJong of the Rhode Island Medical Society Library and to Miss Marion Brown of the Special Collections Depart-

ment of the John Hay Library at Brown University for their invaluable assistance in bibliographical research. I should like also to remember Miss Marie Clair, my faithful secretary, for her sympathetic criticism and patient attention to detail, and in addition all those who have aided me with the chore of proofreading and with helpful suggestions.

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DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport Medical Society was called to order at 8:30 P.M. on September 28 by Dr. Robert Bestoso, President.

The meeting took place at the Hotel Viking with twenty-two members attending. The minutes of the previous meeting were read and approved.

The applications to the County Medical Society of Dr. Olga Torres, Dr. Anthony Carrellas and Dr. William F. Thompson were read before the Society and were referred to the Board of Censors.

It was accepted that the payments for the yellow page telephone listings be paid henceforth by the Society and not by the Hospital.

The Secretary was instructed to write to the Fall River Medical Society concerning what was considered as unethical advertising by Fall River practitioners of their specialties in the Newport telephone directory. He was in addition, instructed to send a letter to this effect to the A.M.A.

NEW BUSINESS. A motion was made that the critical situation at the hospital parking lot for doctors be referred to the director of the hospital for serious consideration, and that steps be taken that the parking lot be reserved *unconditionally* for doctors during the morning hours. This was seconded by the Society and passed.

LIAISON COMMITTEE REPORTS. Dr. Callahan wished to be informed of the matters which the Society, as a whole, would be concerned with pertaining to the Physicians Service Plan. It was unanimously agreed that we suggest the plans give the subscribers first day coverage.

Dr. Ceppi wished, in view of difficulties that have already ensued, that a standard procedure for hiring and firing a school doctor be instituted and arranged by the State Committee, and the Secretary be instructed to forward this suggestion to the State Society.

This motion was unanimously passed by the entire Society.

The meeting adjourned at 10:30 P.M.

Respectfully submitted,
José M. Ramos, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, October 3, 1955. The meeting was called to order by the President, Dr. Francis H. Chafee, at 8:30 P.M.

The minutes of the previous meeting were approved as published in the Rhode Island Medical Journal.

Report of the Secretary

Dr. Michael DiMaio, Secretary of the Association, reported the following actions of the Executive Committee:

It approved the appointment by the President of the Association of Drs. Merle M. Potter and Betty Mathieu as the official delegates of the Association at a Providence White House Conference on Education.

It approved the appointment as a liaison committee between the members of the Association and the administrative office and Claims Committee of Physicians Service the following committee: Dr. Joseph Hindle, Dr. Walter S. Jones, and Dr. Ernest K. Landsteiner.

It approved the work of the Association's Committee on Group Health and Accident Insurance, and it commended the Committee for its work in securing additional benefits for the members effective in September.

It approved the following changes in dates for meetings of the Association in coming months:

1. That the December meeting be transferred to Monday, November 28, in order to avoid conflicts with the American Medical Association Interim Session in Boston.

2. That the Annual Meeting be held on Monday, January 9, instead of Monday, January 2, 1956.

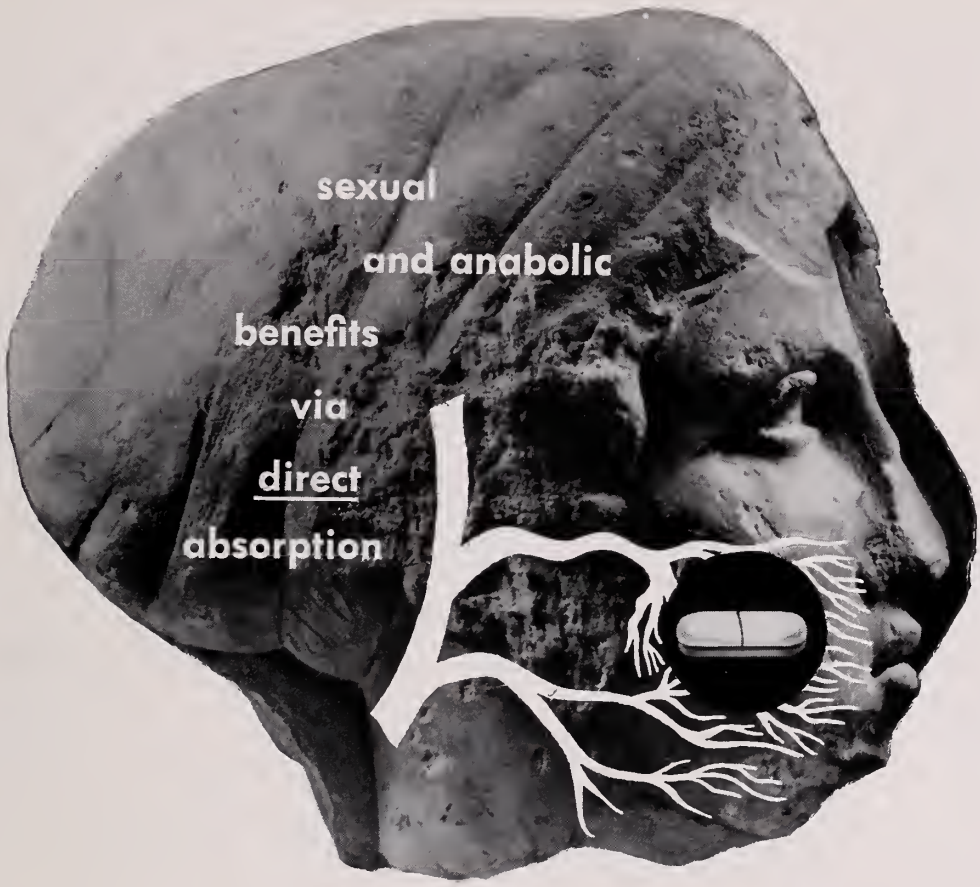
The Executive Committee also approved the appointment by the President of Dr. Joseph G. McWilliams to fill the unexpired term on the Executive Committee of Dr. David J. LaFia, who has moved out of Rhode Island.

Action: It was moved that the report of the Secretary and the actions of the Executive Committee be received and approved. Motion was seconded and adopted.

Report of the President

The President reported that the Secretary is in receipt of obituary tributes to become permanent records of the Association, as follows: to the late

continued on page 654



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PROVIDENCE MEDICAL ASSOCIATION

continued from page 652

Doctor George H. Alexander, prepared by Doctors Henry H. Babcock and Arthur H. Ruggles; to the late Doctor John Langdon, prepared by Doctors Henry E. Utter and William P. Buffum; to the late Doctor Harvey B. Sanborn, prepared by Doctors Elihu S. Wing, Sr. and William Newton Hughes; to the late Doctor George L. Shattuck, prepared by Doctors Halsey DeWolf and Herbert G. Partridge.

He also reported that he had named as a committee to prepare the tribute to the late Doctor Joseph C. O'Connell, Doctors John G. Walsh and John E. Donley.

Doctor Chafee called for a moment of silence to the memory of the physicians who died since the last meeting of the Association.

Award of Membership Certificates

The President awarded membership certificates to the physicians elected to active membership in the Association at the April meeting.

Nominations for Membership

The Secretary reported that the Executive Committee recommends for election the following: Paul Arthur Blackmore, M.D., 141 Waterman Street, Providence, Rhode Island, sponsored by: Drs. John Turner II and Michael DiMaio; Joseph E. Caruolo, M.D., 400 Angell Street, Providence, sponsored by: Drs. Edward Cardillo and Hilary H. Connor; Robert E. Newhouse, M.D., 359 Broad Street, Providence, sponsored by: Drs. John A. Rogue and William F. Maher; Joel S. Ordaz, M.D., 81 South Angell Street, Providence, sponsored by: Drs. John F. Gilman and Frederic W. Easton; George Resnevic, M.D., Putnam Pike, Chepachet, sponsored by: Drs. Joseph G. McWilliams and William S. Klutz; Stanislava Resnevic, M.D., Putnam Pike, Chepachet, sponsored by: Drs. Hannibal Hamlin and Thaddeus A. Krolicki; Lester L. Vargas, M.D., 154 Waterman Street, Providence, sponsored by: Drs. Thomas Perry, Jr. and John Turner II.

The Executive Committee also recommends for re-election as an active member of the Society Dr. John A. Picozzi, 358 Broadway, Providence.

Action: It was moved that the recommendations regarding new members in the Association be approved. Motion was seconded and adopted.

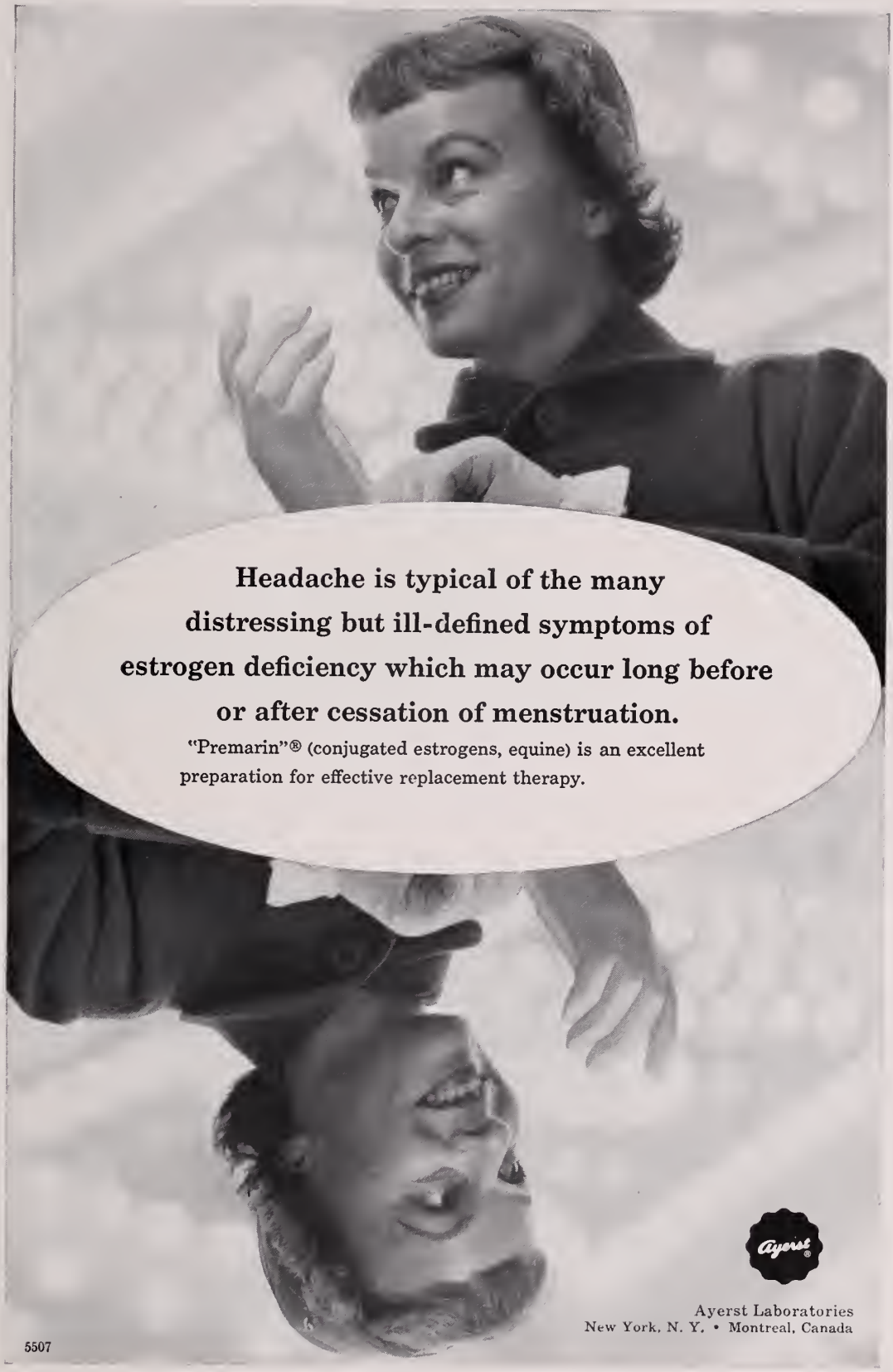
Scientific Program

Dr. Chafee presented the panel for the Clinico-pathological Conference as follows:

Moderator: Marshall N. Fulton, M.D., Chief of Medical Service, Rhode Island Hospital.

Clinical Discussors: John C. Leonard, M.D., Director of Medical Education, Hartford Hospital; Associate Clinical Professor of Medicine, Yale

concluded on page 661


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BOOK REVIEWS

CASIMIR FUNK: PIONEER IN VITAMINS AND HORMONES by Benjamin Harrow. Dodd Mead and Company.

All physicians know that Casimir Funk did some of the earliest work on, and gave the name to, vitamins. Dr. Harrow, who is a chemist and interested in the same type of work that Dr. Funk is, and who is also a great friend of Dr. Funk, has written this book which is almost a eulogy. I think it will be very illuminating to many of the medical profession.

Casimir Funk was a Pole of Russian domination in his youth, but he worked in many of the countries of Europe and got well acquainted with them and their languages, and then worked in this country where he is at the present time. If he is as good as Dr. Harrow thinks he is, and I see no reason to doubt it, he is a remarkable man. He has worked at innumerable projects associated with vitamins which broadly interpreted means that he pretty well covers the field of bio-chemistry, and he has been over and over a pioneer.

The book is divided into two parts. The first largely concerned with his life, and the second with the different problems which he has taken up.

I think the book will be an eye opener to most of the men who read it, and we are delighted to have it in our library.

PETER PINEO CHASE, M.D.

IL SANGUE E GLI ORGANI EMOLINFOPOIETICI NELL' INFEZIONE SIFILITICA (The Blood and the Blood Forming Organs in Syphilis) by Gian Battista Cottini. Editoria Liviana, Padova, 1947

In this 238-page monograph of orientation toward a better knowledge of the blood in syphilis, Cottini says that, in general, the red blood cells and the hemoglobin are diminished and the white blood cells increased. These changes are not specific. It is in accord with Fournier's triad; namely, less erythrocytes, less hemoglobin and leukocytosis. This applies also to prenatal syphilis.

The changes appear as a defense mechanism of reticulo-histiocytary-allergic nature. The bone marrow and the spleen are considerably altered.

The monograph represents an important collection of data. It should be of interest and value to the student of syphilology, who is trying to clarify many uncertain points on the subject of blood and syphilis.

F. RONCHESE, M.D.

SALT AND THE HEART by Edward T. Yorke, M.D. Drapkin Books, Linden, N. J., 1953. $3.45

This is an interesting little book written by a physician whose prime interest is cardiology. The first part of the book is written in narrative style and is devoted to the effect of salt on cardiovascular disease, particularly congestive heart failure. This portion of the book is very elementary but the author's approach to the subject is quite interesting. The story is about an old, retired sea captain, "Old Salt," who is unable to tolerate the unrestricted use of salt in his daily diet.

The second part of the book is devoted to the preparation of a low sodium diet which is, perhaps, the most important part of the book. The subject is presented in such a manner that even the layman can prepare a low sodium diet with reasonable accuracy. The book is recommended as supplementary reading for the general practitioner and the layman.

MICHAEL DIMAIO, M.D.

OGGI NON VISITO . . . PERCHÈ MI GIRA . . . LASCIO IL TERMOMETRO . . . PRENDO LA LIRA (Closed Today . . . I Just Don't Care . . . I Leave the Thermometer . . . and Take Up the Lyre) by Ugo Piazza. Edizioni Minerva Medica, Torino, 1955, Lire 1500

Dr. Piazza is a popular figure among the Italo-Americans of Providence, since his visit to the city two years ago and his weekly broadcasts from Rome on station WRIB. Dr. Piazza has a large family, a large dermatologic practice, right in the heart of the Eternal City, and is kept busy by the medical press. In addition to all these activities and to relax from the busy daily routine, he composes medical comical poetry of a most enjoyable kind. His verses are coming out with the speed of a high pressure pure water spring and are delightful.

concluded on page 658

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BOOK REVIEWS

concluded from page 656

The poet-wit has a field day with our dermatologic puzzles, with the warring pediculus, the spirochetes, the inevitable enema, the vitamins craze, the detail man eloquence, etc., etc.

A serene, laughing Aesculapius, offering his peaceful mind as a reminder that there is always time for a good clean laugh.

The book is well illustrated by cartoonist Fratalocchi.

The cartoon on allergy, for example, shows an Italian forced to refuse a most alluring dish of spaghetti because of the clam sauce. Interesting are the verses devoted to medical history.

The book represents a valuable addition to our unique Davenport collection of books by physicians on non-medical subjects. I hope a Piazza-minded colleague, versed in both languages, will give us an English translation.

F. Ronchese, M.D.

A TEXTBOOK OF PHYSIOLOGY. Edited by John F. Fulton with the Collaboration of Others. 17th ed. W. B. Saunders Company. Phil., 1955. $13.50

This new edition of physiology text presents many revisions and additions to older concepts so that even the recent medical graduate will find a wealth of material to absorb. Exactly fifty years have passed since the first edition by Doctor Howell and five years since the sixteenth edition. Among the contributors is Paul F. Fenton of our own Brown University Biology Department writing on the digestive system. Among the advances in fundamental physiology now included are completely rewritten chapters on the physiology of the nervous system (for which the book in the past was highly regarded), body fluids, kidney function, respiration and a new chapter on energy transformation in nerve cells and acetylcholine by Doctor David Nachmansohn, the eminent authority in this field. Recent important change in concept of the regulation of the autonomic nervous system by the visceral brain is recognized by a new chapter on the limbic system which brings to the fore the part played by the cerebrum in regulating visceral function and patterns of emotional expression. It was startling to read that the hypothalamus is no longer considered the chief area of autonomic function in the forebrain, but that in the oldest part of the cerebral cortex there is a designated limbic system to influence autonomic reactions. Although these studies are in their infancy, they are providing a rational basis for certain behavioral and EEG manifestations of psychomotor epilepsy.

To the reviewer the chapter on hemodynamics of the blood was a welcome revelation of some of the principles of the rapidly expanding field of rheology, the science of flow and elasticity, not easily found elsewhere.

The illustrations, tables and references are well up to date for a subject that expands as physiology does. One instance was noted where the figures of a table taken from another recent text on body water were revised again by that author to be the latest available data. The authors are to be commended on their revisions and exclusion of unessential material making the subject matter more digestible to the student and practitioner alike.

Abraham Saltzman, M.D.

PRESENT-DAY PSYCHOLOGY edited by A. A. Roback. Philosophical Library, New York, 1955. $12.00

This new anthology brings up to date the experimental work in human behavior. The compilation covers the various areas of depth psychology from the point of view of recognized experts in each particular dissection of the human person.

The whole volume deserves attention because of its fine presentation and clear exposition of the present experimental situation and needs in the areas considered.

Thumbing through this book leaves one with a feeling of having had an adventure in the world of psychological ideas. No matter what one's personal idea about psychology might be, he recognizes the service this anthology renders to the profession in the depth, scholarship and magnitude of the work (995 pages).

For the student of psychology the full treatment of basic issues in experimental psychology is presented in one volume. For the busy clinician and doctor it is a sourcebook ready at hand.

The anthology should be a valuable addition to the library of psychological literature.

Robert G. Quinn, O.P., A.M., M.Ed.

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BEGINNINGS OF MEDICAL EDUCATION IN R. I.

concluded from page 651

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KEY—JHL: John Hay Library, Brown University;
RIHS: Rhode Island Historical Society Library;
PPL: Providence Public Library;
RIMS: Rhode Island Medical Society Library;
RIH: Rhode Island Hospital Library;
MS: Manuscript.

PROVIDENCE MEDICAL ASSOCIATION

concluded from page 654

Medical School. Thomas A. Warthin, M.D., Chief of Medical Service, West Roxbury Veterans Hospital; Associate Clinical Professor of Medicine, Harvard Medical School.

The summary of the case was submitted to the membership in advance of the meeting.

As has been the case in the past two years, the first scientific meeting of the year was very successful. The discussion of the case was excellently handled by the visiting physicians, Dr. John C. Leonard and Dr. Thomas A. Warthin. Dr. Marshall N. Fulton did an excellent job as moderator of the conference.

The diagnosis of the case was an undifferentiated bronchogenic carcinoma of the lung with metastases to the liver, brain and adrenal glands. The patient also had acanthosis nigricans.

The meeting was adjourned at 10:00 P.M.

Collation was served.

Attendance: 105.

PHLEBITIS

concluded from page 631

bolism, a major operation such as a vena cava division should not be done. Sometimes a large clot may be present and give a few physical signs. In such cases I believe the electrocardiogram is of value in demonstrating right heart strain. If this is the case, anticoagulant therapy rather than vena cava division is the choice.

Many physicians believe that a vein division produces a higher percentage of the postphlebitic syndrome than other methods of treatment. This is very difficult to evaluate, and I know of no definitive study. From our own experience, I believe that the postphlebitic syndrome is more closely related to the severity of the initial phlebitis than to the type of therapy used.

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WHAT HAVE YOU TO SAY ABOUT HOSPITAL ACCREDITATION?

In June, 1955, the House of Delegates of the American Medical Association authorized the Speaker to appoint a committee " . . . to review the functions of the Joint Commission on Accreditation of Hospitals . . ." and ". . . to make an independent study or survey and report its findings and recommendations to the House of Delegates at the next annual meeting. All physicians and hospitals are urged to pass on to this special committee any observations or suggestions concerning the functioning of the Joint Commission on Accreditation of Hospitals."

This Committee was appointed, and now, in undertaking the task assigned to it, is seeking to obtain from physicians and others their observations concerning the functioning of the Joint Commission.

It is obviously impossible for the Committee to contact all physicians and others who may have observations or comments concerning the matter of hospital accreditation.

The Committee, therefore, is publishing this appeal, through the cooperation of the RHODE ISLAND MEDICAL JOURNAL, to obtain a cross section of observations concerning the accreditation program.

The Committee is interested especially in the following:

1. The general understanding by physicians of the functions of the Joint Commission.
2. Whether the method of appeal from an adverse ruling regarding accreditation is satisfactory.
3. The effect on the individual physician's hospital connections due to actions of the Joint Commission.
4. Whether any organizations not now represented should have official representation on the Joint Commission.
5. The effect of the Joint Commission's requirements concerning such matters as staff meetings.
6. The pros and cons of separating administrative and professional accreditation functions in the inspection of hospitals.
7. Constructive suggestions for improving the hospital accreditation program.

Any comments from individual members or state and county societies should be addressed to:

W. C. Stover, M.D., *Chairman*
Committee to Review Functions of Joint
Commission on Accreditation of Hospitals.
535 North Dearborn Street
Chicago 10, Illinois

These comments should reach the chairman not later than January 15, 1956.

W. C. Stover, M.D., *Chairman,* Boonville, Indiana
John F. Burton, M.D., Oklahoma City, Oklahoma
Gerald D. Dorman, M.D., New York, New York
George F. Gsell, M.D., Wichita, Kansas
Eugene F. Hoffman, M.D., Los Angeles, California
T. C. Terrell, M.D., Fort Worth, Texas
George Unfug, M.D., Pueblo, Colorado

109TH ANNUAL MEETING

of the

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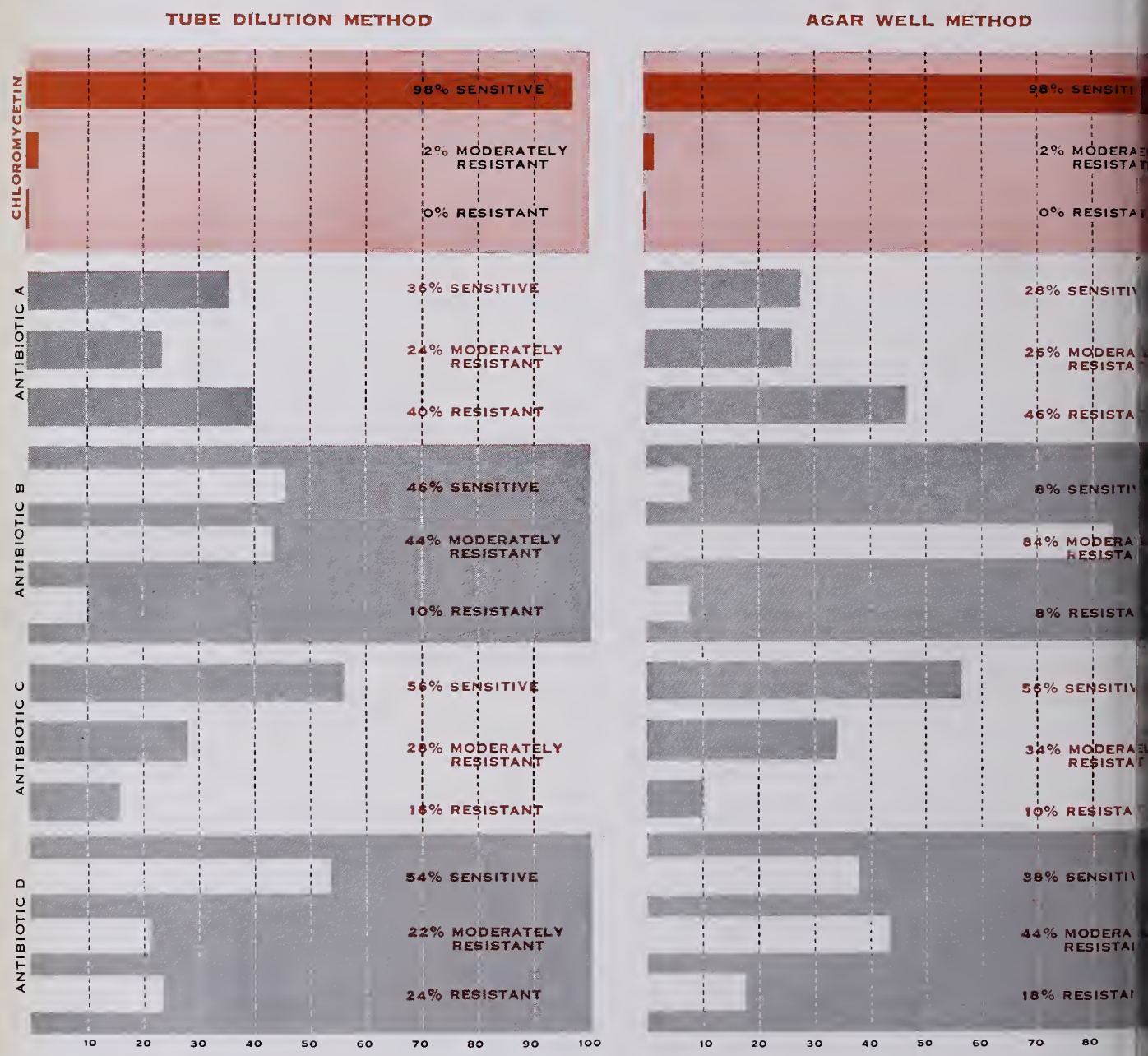
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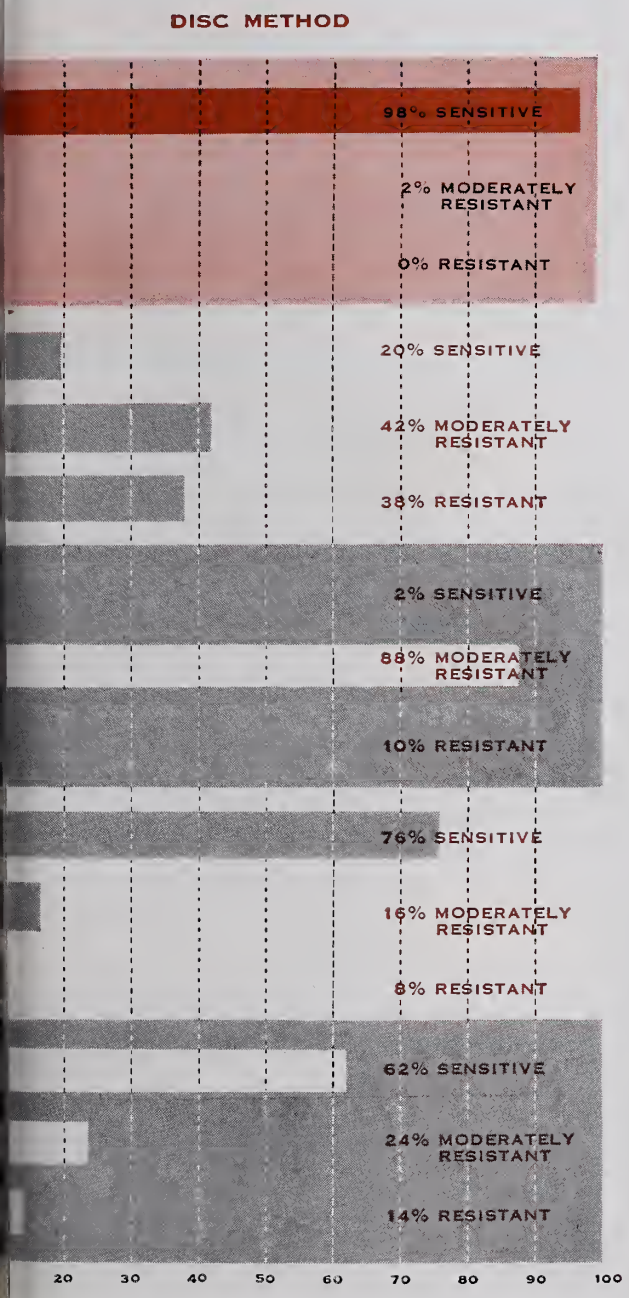
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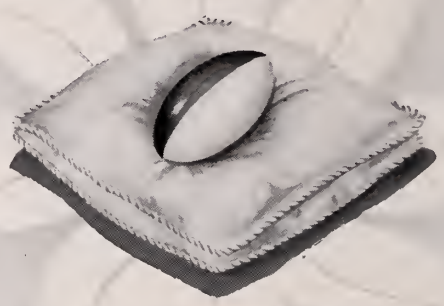
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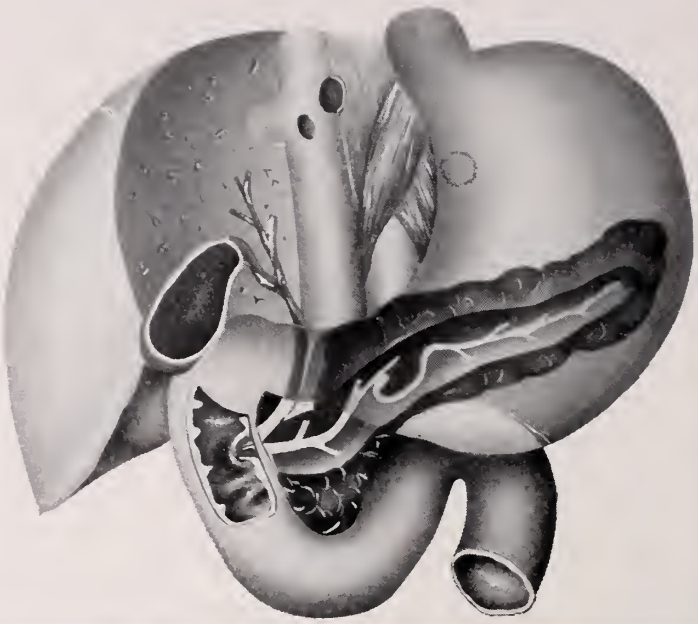
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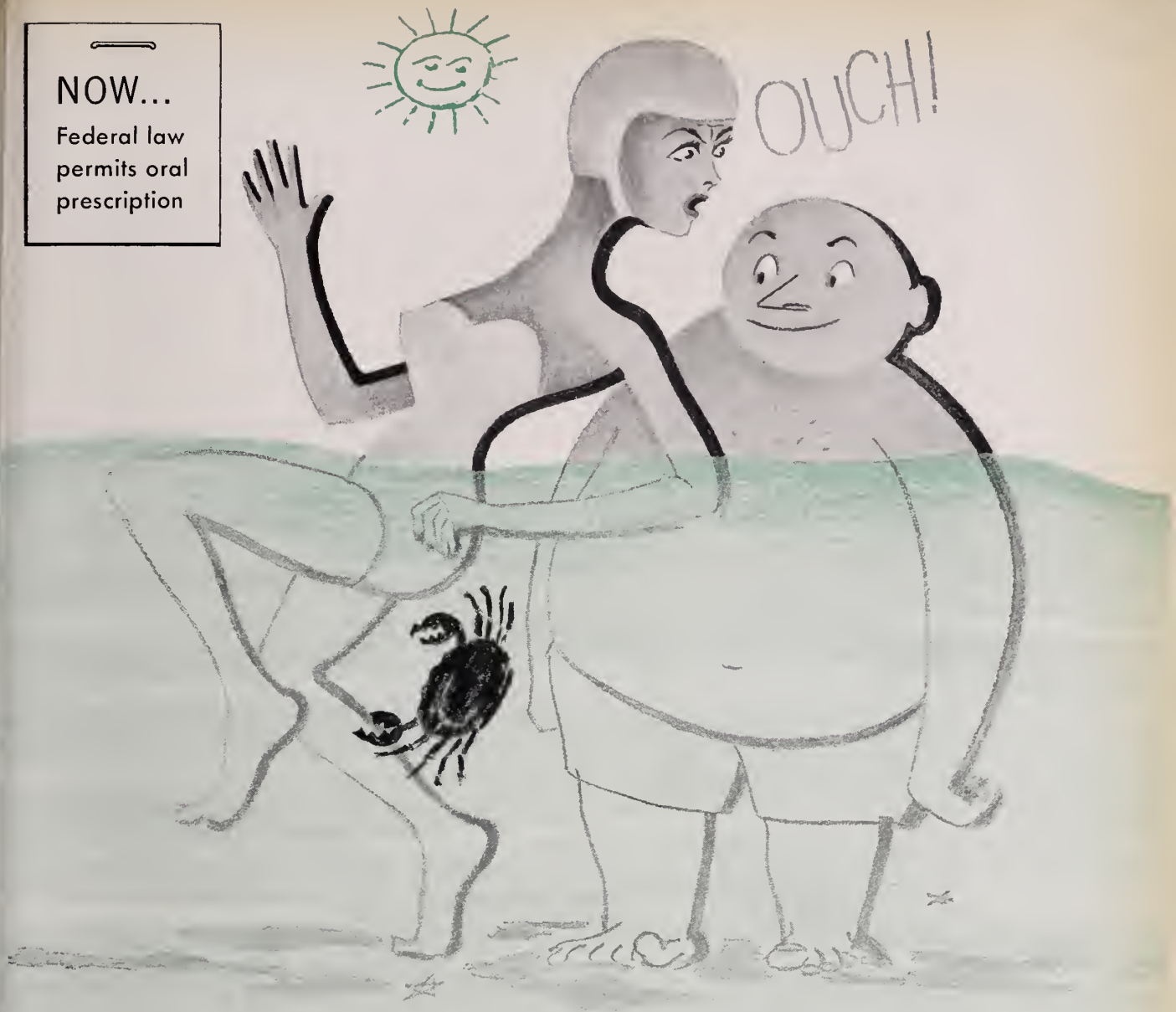
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*King, J. C.: Am. J. Digest. Dis. *22*:102, April, 1955.

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1. Piper, C. E., and Nicklas, F. W.: Indust. Med. 23:510, 1954.

Pork in the Dietary During Pregnancy and Lactation

CERTAIN NUTRIENTS are required in greater than normal amounts during pregnancy and lactation. Pork meat, though its cost is low, supplies a remarkably high quantity of the nutrients required by the maternal organism in these periods of physiologic need.

During pregnancy the maternal organism may store 3.3 to 5.5 pounds of protein in excess of that contributed to fetal tissue.[1] Enough iron is stored to approximate the entire amount secreted in the milk during 9 months of lactation, in addition to the iron supplied to the fetus.[2]

The body of the newborn infant contains approximately 500 grams of protein, 14 grams of phosphorus, and 0.5 gram of iron.[3] It is estimated that the lactating mother, through breast milk, provides a 26 week old infant with about 12 grams of protein, 76 grams of lactose, and 1.2 mg. of iron each day.[2]

Pork meat, an excellent source of high quality protein, thiamine, niacin, and iron,[4] also supplies valuable amounts of other B vitamins, as well as phosphorus, magnesium, and potassium. The thiamine content of pork is particularly important, since there are few more valuable food sources of this vitamin.[4]

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1. Toverud, K.U.; Stearns, G., and Macy, I.G.: Maternal Nutrition and Child Health, an Interpretative Review, Washington, D.C., National Research Council, Bull. 123, 1950.

2. McLester, J.S., and Darby, W.J.: Nutrition and Diet in Health and Disease, ed. 6, Philadelphia, W.B. Saunders Company, 1952, p. 241.

3. Marrack, J.R.: Food and Planning, London, Victor Gollancz, Ltd., 1943, p. 67.

4. Wolgamot, I.H., and Fincher, L.J.: Pork Facts for Consumer Education, Washington, D.C., United States Department of Agriculture, AIB No. 109, 1954.

5. Watt, B.K., and Merrill, A.L.: Composition of Foods—Raw, Processed, Prepared, Washington, D.C., United States Department of Agriculture, Agricultural Handbook No. 8, 1950.

6. Bowes, A. deP., and Church, C.F.: Food Values of Portions Commonly Used, ed. 7, Philadelphia, Anna dePlanter Bowes, 1951.

Percentages of Recommended Daily Dietary Allowances* for Pregnant (3rd Trimester) and Lactating Women Provided by 3-Ounce Portions of Cooked Pork Meats and Pork Sausage

	Protein	Iron	Phosphorus	Thiamine	Riboflavin	Niacin	Calories
PREGNANCY (3rd trimester)							
Ham, without bone, 3 oz., cooked[5]	25.0%	17.3%	13.5%	30.0%	10.0%	26.7%	12.5%
Pork Chops, without bone, 3 oz., cooked[5]	25.0%	17.3%	13.3%	47.3%	10.0%	28.7%	10.5%
Pork Sausage, 3 oz., cooked[6]	17.3%	14.0%	9.2%	27.7%	10.1%	18.5%	14.7%
LACTATION							
Ham, without bone, 3 oz., cooked[5]	20.0%	17.3%	10.1%	30.0%	8.0%	26.7%	10.2%
Pork Chops, without bone, 3 oz., cooked[5]	20.0%	17.3%	10.0%	47.3%	8.0%	28.7%	8.6%
Pork Sausage, 3 oz., cooked[6]	13.8%	14.0%	6.9%	27.7%	8.1%	18.5%	12.0%

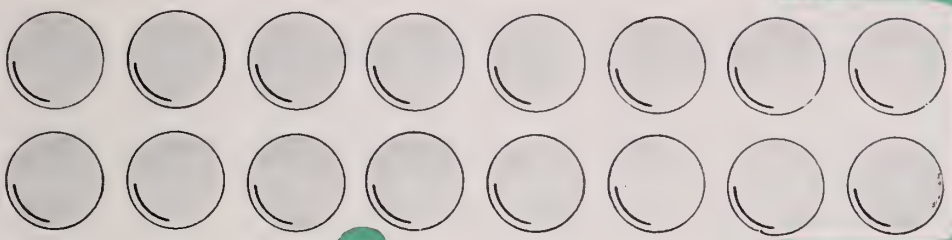
*Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953

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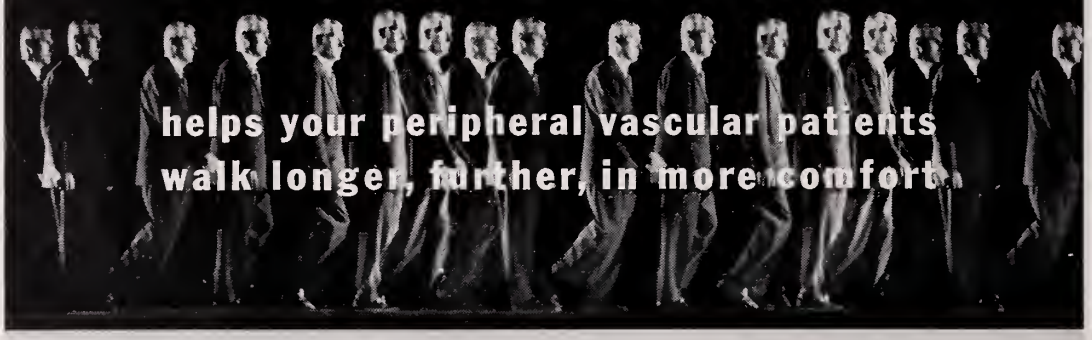
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1. Pomeranze, J. et al.: Angiology, June, 1955.
2. Freedman, L.: Angiology 6:52, Feb. 1955.

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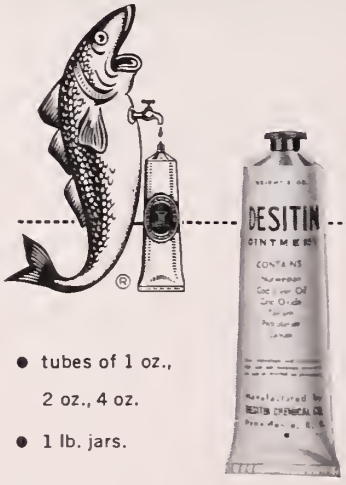
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1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. Med. 53:2233, 1953. **2.** Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951. **3.** Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery 18:512, 1949. **4.** Turell, R.: New York St. J. Med. 50:2282, 1950. **5.** Marks, M. M.: Missouri Med. 52:187, 1955.

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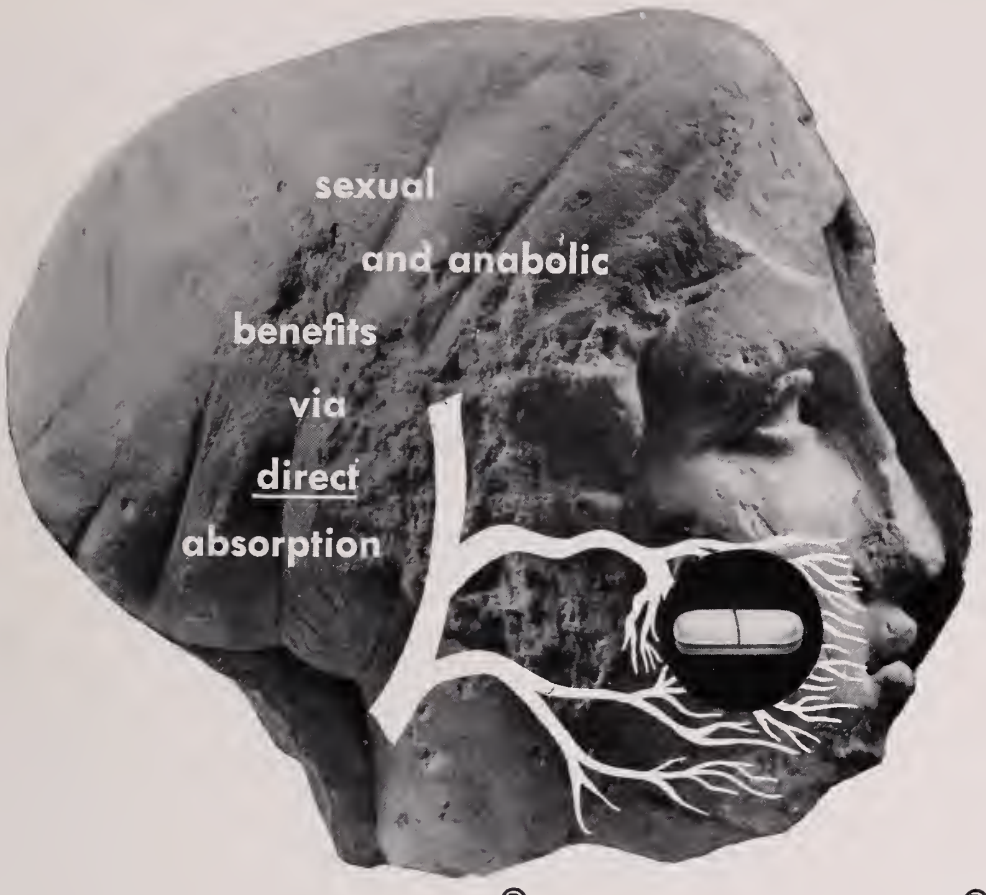


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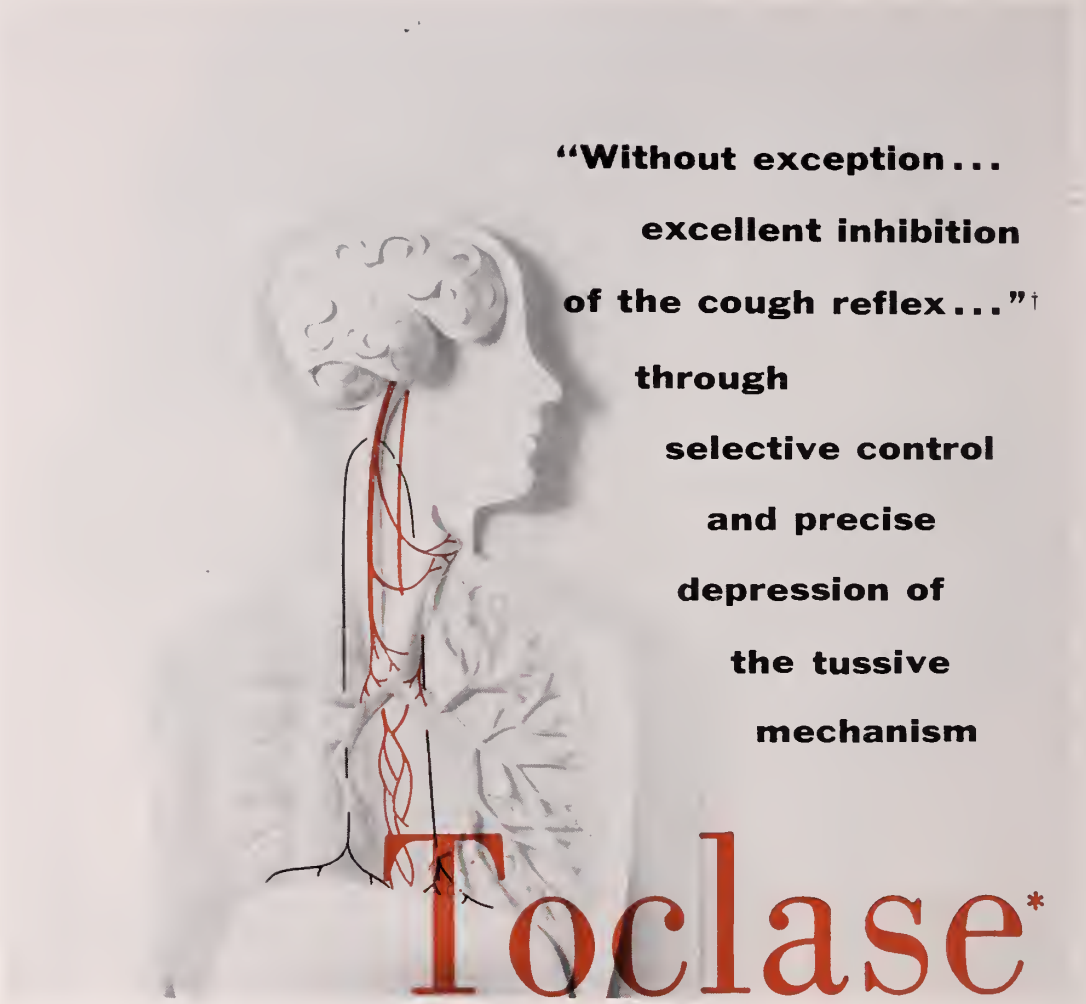
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXVIII DECEMBER, 1955 NO. 12

THE STORY OF THE HEART STATION at the RHODE ISLAND HOSPITAL

FRANK T. FULTON, M.D.

THE RHODE ISLAND MEDICAL JOURNAL is particularly pleased and proud to have the honor of publishing this story by one of the earliest students of the heart in America, the chief of cardiology at Rhode Island Hospital for many, many years, and the dean of Rhode Island physicians — Doctor Frank T. Fulton.

. . . THE EDITORS

IN WRITING of the early history of the electrocardiograph and its use in the study and diagnosis of heart disease, one needs mention but two names: Willem Einthoven and Sir Thomas Lewis. The development of the instrument, itself, was comparatively rapid, and its usefulness was due almost entirely to Einthoven, while its application to the study and diagnosis of heart disease was due to Lewis. Einthoven was professor of physiology at the University of Leyden. He perfected a string galvanometer which was much more highly sensitive than any then in use. It could detect and measure the strength and direction of the smallest possible electric current associated with the heartbeat. This work was reported in papers published in 1907 and 1908.

Lewis became interested in electric currents associated with physical activity. The discovery of fibrillation in dogs and horses, upon which electrocardiographic records had been made about 1909 stimulated the more systematic observations in the human. Arthur R. Cushney, professor of medicine and pharmacology at the University of Edinburgh was associated in these observations.

In 1907 Lewis came in contact with Sir James Mackenzie who had recently come to London. Sir James was a resident of Burnley and had spent his life there in general practice up to that time. He was greatly interested in the heart action and irregularities and in his studies used an ink polygraph. He and Lewis subsequently became very friendly, altho their interpretations of the meaning of the different irregularities were not always in accord. The preface of Dr. Lewis' book, "The Mechanism of the Heart Beat," was written in December 1910. I first obtained this book in 1911, soon after it was published.

At the end of 1909 I had resigned as director of the pathological department at the Rhode Island Hospital and was appointed as visiting physician on the medical staff. At this time I moved my office and some of the announcement cards which I sent out had, inconspicuously in the lower left-hand corner, "Internal Medicine." I also sent some which did not have that designation, the reason being that the term had hardly become known in Providence and I didn't want to seem to be ostentatious. No one else in the city up to that time had declared himself as an internist.

During my first three years in Providence (1900-1903) I lived in the hospital and was in very close touch with practically all of the interesting cases on both the medical and surgical services and occasionally some of the specialties. This was because I was so intimately associated with the interns that I would usually hear of these patients, and there was always the opportunity to make observations and perhaps help in working out the diagnosis. Then, too, having the direction of the pathological work, I saw and had a chance to examine many of the cases after death and could compare what was actually found, with what had been believed to be present during life. The cardiovascular diseases always interested me more than any other phase of Medicine and after I became a member of the visiting staff, my interest was intensified and cases of that type got rather more attention from me than those simply of general Medicine.

Dr. Lewis' book represented one of the high spots in the advancement of our understanding of the cardiovascular system. It was a difficult book to read because it took one so far in advance of the general knowledge at that time. I decided during the winter of 1911-1912 that I would go to London and get a better understanding by doing some work in Dr. Lewis' laboratory. I sailed on

continued on next page

July 10th, 1912 and had as my companion, Dr. Dewey Alsever, who had been an intern at the Rhode Island Hospital and who also was interested in Internal Medicine. Our main purpose in making this trip was the study of heart disease.

On arriving in London we went to see Dr. Lewis at the University College Medical School. We found him very cordial. He was still young, 31 years of age, fourteen years younger than I. After telling him why we had come, he suggested that we come in for a week to see if we thought it would be worthwhile to spend the summer with him, in which case he would be glad to have us.

The next morning we called on Sir James Mackenzie, to whom we had a letter of introduction, to ask his advice and he said by all means, if there was an opportunity we should avail ourselves of it, adding that he thought Lewis the best informed man in Europe at that time in the recent knowledge of cardiovascular diseases and the normal function of the cardiovascular system.

When we returned to begin our work with Lewis we found there were already four young fellows who were there to learn what he was doing. He was busy during the summer a good deal of the time with some research problem, for that was his particular interest; however, he gave up a certain part of his time to teaching. Occasionally he would give a lecture which was always good. His faculty of expressing himself very clearly made a difficult subject comprehensible and interesting.

The first thing we were made to understand was the mechanism of the normal heart action. Lewis had analyzed and classified very definitely the various types of irregularities. Until then they were not generally well understood, though Sir James Mackenzie had identified them fairly well by the use of his ink polygraph. Lewis had been using that and had a large collection of tracings which were mounted in a book and we were given the task of studying these and interpreting the type of irregularity which each represented. He didn't approve of our seeing any electrocardiograms until we had been through that set of polygraph tracings. After that we were allowed to go through his collection of electrocardiograms of irregular hearts and found at once it was the lazy man's way of getting the facts, because they were presented so much more clearly and definitely. The study of the polygraph records, however, was valuable because one had really to put in a good deal more thought and ingenuity to get a correct interpretation. Eventually each man was allowed to operate the electrocardiograph and toward the end of our stay Dr. Lewis took tracings of each of us.

I felt that I learned more in that short summer with Lewis than in any period of the same length during my medical life up to then. The advantage of having an electrocardiograph to use to verify the abnormal mechanisms was greatly impressed upon me; however, a Mackenzie ink polygraph could be bought for fifty dollars and an electrocardiograph would cost fifteen hundred. On that account Alsever and I each came home with a polygraph.

Dr. Lewis, while he always treated us courteously, was not always very approachable. He volunteered in conversation rather seldom, but in his lectures he was extraordinarily clear. It was a pleasure and satisfaction to have him discuss for us any pertinent subject. At the end of the summer the six of us who had been there for several weeks wanted to do something to show our appreciation for all that he had done for us. We didn't know just what to do, but asked Sir James Mackenzie if he could give us any ideas. He at once said: "Take him out to dinner and give him a good time. I think that would be the most suitable thing and perhaps please him more than anything else; at any rate, that is the sort of thing he needs." We asked Sir James to join us but for some reason he was unable to, so we put it up to Dr. Lewis, asking him to have dinner with us at the famous eating house, Simpson's on the Strand, where we had reserved a table. Lewis entered right into the idea, himself, and rather took over, as being a resident and understanding customs of the place, and he seemed to have a very good time. He became quite talkative, which was rather unusual with him and added greatly to our own interest. At the end of the dinner he took over altogether and invited us to go with him to a club where we could sit and visit. It was quite a delightful evening for us because Lewis had never shown his social side at all to any of us.

After we stopped work at the University College Alsever and I went to Edinburgh. We wanted to see the Royal Infirmary there and also to meet Dr. Ritchie, who had already identified auricular flutter and made the first definite study of that abnormal rhythm.

The knowledge of the heart's pathological anatomy and physiology was still quite limited. Heart block was well recognized and the bundle of His was known and its function quite well understood, in that when it was impaired, heart block would occur and the auricles and ventricles would beat independently of each other. However, the sinus node, which gives rise to the stimulus, the auriculo-ventricular node, the branches of His' muscle bundle and their distribution in the form of the Purkinje network had only just been demonstrated and it has been very interesting to note the development of the knowledge of these separate structures and the dependence of the heart upon their sound formation and ability to function. I,

personally, had never seen the muscle bundle of His dissected out until I did it, myself, on calves' hearts in 1912 after my return from this summer in Europe with Dr. Lewis. Just before we came away Lewis brought in a beef heart in which the arborizations of the bundle (the Purkinje network) had been injected. This was enough to get my interest and curiosity much aroused, and when I got home one of the first things I did was to go to a slaughterhouse and make arrangements with them to be present when they were slaughtering calves and to get some hearts for the purpose of demonstrating the whole conducting system. It was rather difficult to get them and if the first attempt at injection was a failure the heart was no longer useful. Finally, I purchased at the Providence Public Market a dozen pig hearts and took them to the hospital to try out this procedure. Ultimately I got several tolerably good injections—a couple of very good ones, much better than any Lewis had shown us. The photograph of one of these hangs now in the Heart Station. It was a lot of fun to show these specimens to some of my friends in the pathological laboratory at the Peter Bent Brigham Hospital, who had not yet seen this structure demonstrated. This network is enclosed throughout its extent by a sheath and the distribution was clearly shown by the use of India ink injected from a hypodermic syringe into the sheath. With good luck one could see very promptly, within two or three seconds, the ink flowing throughout the entire network. It made a beautiful specimen. I had one of these preserved in a museum jar for a good many years. It was used repeatedly for demonstration, until finally someone carelessly left it to dry up and thus it became useless for that purpose. This injection, as stated, was done in 1912. I find in my file a very nice note dated Oct. 14, 1913, from Dr. Geo. W. Norris, Professor of Clinical Medicine at the University of Pennsylvania and co-author of Norris' & Landis' "Diseases of the Chest and the Principles of Physical Diagnosis," as follows:

> "Please accept my cordial thanks for your kindness in sending me the lantern slide of the injected heart. It will be of great service to me in teaching, and I wish to congratulate you again on the ingenuity of the method which you have employed as well as upon the beautiful technique which you have developed."

This complimentary note compensated for some of the hard work I put into getting a satisfactory result in my attempts to show up the conducting system.

In the winter of that same year, while on service at the hospital, I discovered on Ward A two cases of auricular flutter which I analyzed and made the subject of a paper that I read at a meeting in Washington, D. C. in 1913. This was published in the "Archives of Internal Medicine" in October. These were the first cases noted and published in this country.

I spent a lot of time in the next two years working with the polygraph, making tracings on every patient in whom there was any irregularity of heart action that came under my observation. I used it in the medical wards through the courtesy of the visiting men, where I thought it would give useful information, and I had a lot of fun with it during this time. I went to Boston often. There, at the Brigham Hospital, which had just been opened, the atmosphere on the medical service was very cordial and friendly and I was invited to come at any time and make any observations on the cardiac cases that were in the wards. I had known well some of the members of the staff. Dr. Christian was in charge; Doctors Peabody, Reginald Fitz and Frothingham were on the staff and were all interested in heart disease, but the Brigham had not yet installed an electrocardiograph. Contact with these Boston men was very stimulating. Altogether, I learned a good deal during the two years after I had been abroad the first time studying in Lewis' laboratory.

Before the end of two years, my desire for an electrocardiograph had brought me to the determination to get one. At first I was puzzled to know how I could make it worthwhile. My office was such that I couldn't accommodate an instrument of that sort because it would take up so much room that it was out of the question. In Baltimore and in Dr. Mallory's laboratory I had learned of a good many new things. Sometimes suggestions made by me were coldly received by the older men at the Rhode Island Hospital. I was sure there would be no chance of getting favorable action through the staff so I took a short cut by going directly to the Laboratory Committee of the Board of Trustees and offering to buy an electrocardiograph, myself, as I would want one when I got into a more suitable office, proposing in the meantime to put it in the hospital where it could be used for any hospital patient and where I could take my own patients when I wished to, for the purpose of getting records. The only stipulation made was that the apparatus would be under my direction. Before doing anything, I wrote to Dr. Rufus Cole of the Rockefeller Hospital in New York, to Dr. Janeway, Chief of the Medical Service at Johns Hopkins at that time, and to Dr. Wm. Sidney Thayer of Johns Hopkins, to find out whether in their opinions the instrument was likely to have a definite and useful value in the care of certain cases of

continued on next page

heart disease. Following are the replies I had from these men:

September 28, 1913

Dear Fulton:

The electrocardiogram is a great help in some cases, and is a good complement to other methods of clinical study of cardiac disease that we have. It is difficult to say just what its clinical value is, but that it is of a good deal, I can say without hestitation. For instance; it is a simpler and quicker method of making observations than that of taking bedside tracings and in a good many instances, it tells in a few minutes certainly what one has to arrive at by rather more careful and prolonged study in working over a tracing. In some respects, it tells things that tracings do not tell, in other respects, tracings give a little further information. But it seems to me that a well equipped hospital should have one. The difficulty about the matter is that it is a complicated affair, and you will need a good electrician, and one who has made a special study of the instrument to direct it. It cannot be managed by any hospital assistant.

(Signed) W. S. Thayer

October 3, 1913

My dear Fulton:

There is no question as to the value of the electrocardiographic study of heart cases, particularly as a guide to the intelligent use of drugs. In nine out of ten cases one can get the information without the instrument, after he has learned to recognize what the instrument shows. In the tenth case he is pretty sure to miss it without. Polygraphic tracings give most of the information, but really take a great deal more time in the end. If you get a good instrument you will, of course, have to have some one who will take careful charge of it. It is not a thing which can be trusted to a house staff or to the use of several individuals.

(Signed) Theodore C. Janeway

Sept. 27, 1913

Dear Frank:

Our experience here with the electrocardiograph makes us feel that this instrument is of very great value indeed as an aid in the proper diagnosis and treatment of individual cases of heart disease. I do not think that it is too much to say that this instrument has revolutionized our method of treatment, and without it we would be at a loss how to proceed in certain cases. Of course, much information may be obtained from venous tracings, but when the instrument is once set up and in order, it is so convenient to use and the information obtained is much more accurate than that which can be obtained by venous tracings.

As the instrument is used more and more, its value will undoubtedly become increasingly great. I should say, however, that even now it is almost as important for the physician who treats heart disease to have access to an electrocardiographic apparatus as it is for the surgeon to have an X-ray machine.

(Signed) Rufus Cole

My offer to buy an electrocardiograph and install it in the hospital was promptly accepted, according to the following agreement:

Providence, R. I., July 27, 1914

Referring to the proposition made by Dr. Fulton to the Rhode Island Hospital, with regard to an Electrocardiograph, the Board of Trustees of the Hospital agree that if Dr. Fulton will obtain such an instrument, that they will install and maintain it in the Rhode Island Hospital provided that it is made available at all reasonable times for use on the Hospital patients. The operation of the instrument shall remain under Dr. Fulton's direction, and his ownership.

The question of fees for private Hospital patients and for outside patients who are able to pay may be arranged by the patient and Dr. Fulton just as they are arranged in the case of a surgeon who is to perform an operation on a private patient.

Charity patients from the outside shall, of course, receive the same attention free of charge.

This agreement may be terminated after the end of a year from above date by either party, upon notice of not less than thirty days.

Laboratory Committee

(Signed) Charles A. Catlin, *Chairman*
Edward D. Pearce

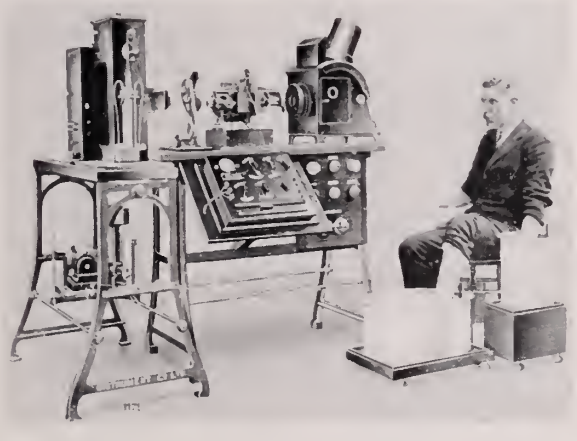
Frank T. Fulton

In the meantime, I had made my plans in any case, to go to London again and pursue further my studies with Dr. Lewis. I sailed on July 31st, 1914. On August 4th our ship was met by two British men-of-war and the announcement was made that war had been declared between Germany and England, and we were convoyed from there until we landed. The first thing I did was to see Dr. Lewis, to find out what his plans were and what the situation was at the University College Hospital. He at once said that probably there would be very little going on there, that his plans hadn't been made, but that there was no doubt in his mind that they would be greatly modified by the war and that for the moment there was no organized work. I went over to Cambridge to see about an electrocardiograph. They told me that the war would hold up their orders and they couldn't promise anything before the following spring. But I ordered one at any rate.

This time in England was rather dull. It was impossible to get any sailing home earlier than the one I had reserved in the beginning; in fact, I had to postpone my return for a week longer than I had planned. During that time, however, I saw something of Dr. Lewis. I had with me a polygraphic tracing of a phase of the circulatory changes in one of the cases of auricular flutter that I had reported the year before. This tracing was taken with one of the tambours of the polygraph on the brachial artery and the other on the chest. This was done to record simultaneously the rate of the breathing and the rate of the pulse. It was quite a remarkable record in that it showed marked changes in the rate of the pulse and the amplitude of the deflections. It was so unusual that Dr. Lewis said it ought to be published, so I wrote up a short account, left it with him and he had it published in the English journal, "Heart," Vol. 6, No. 1, April 1915.

Later that autumn Dr. Lewis came over here upon invitation, to deliver the Harvey and the Herter lectures. He stayed with Dr. Christian in Boston a part of the time and I invited them both to come to Providence on a Saturday and spend the week end with me. On Sunday we drove down through Fall River, crossed over on the Old Stone Bridge at Tiverton and toured through Newport for a while that afternoon. Lewis seemed to get a lot of pleasure out of the trip.

Delivery of the electrocardiograph was not accomplished until March 1915. When it came, it was installed in the X-ray room in the basement of the hospital where there was plenty of spare space. It was very cumbersome (see illustration),



consisting of four definitely separate parts, all of which were mounted in proper relationship to each other upon a 6-foot long table. There was the electrical part of the device, which was the galvanometer, comprising an electromagnet in which there was mounted a microscope, the microscope being focused upon a minute fibre, perhaps four inches in length and about half the diameter of a red blood corpuscle. This fibre was suspended between the two poles of the electromagnet and the current from the patient's heart, passing through this magnetic field, caused a deflection of the fibre. The object of this mechanism was to get a shadow picture of the movement of the fibre. That meant that there must be a light passing through the microscope. The microscope greatly enlarged the shadow of the string and its minute movement. The source of the light was the arc from a set of carbons and the light produced in this way was never very constant. There was always some flickering. The carbons were supposed to feed toward each other automatically but they needed frequent adjusting. Then there was the camera with which the shadow of the string could be photographed. For this purpose, of course the film in the camera must be moving. In addition to what has already been mentioned, it was essential to have a time record made on the moving photographic film. That was accomplished by a large tuning fork attached to a small revolving wheel, the spokes of which were made to pass through the beam of light at the rate of 25 times a second. This cutting off the light for the minute fraction of a second would give the time record of the rate of movement of the photographic film.

As one can easily understand, the job of getting a shadow picture of a moving fibre under these circumstances, in which the mechanism that produced the light, the instrument which contained the moving fibre, the camera, and the timing device were all separate entities, was complicated. All of these parts had to be kept in proper adjustment and working in co-ordination with each other in order to get a record. There were many "gremlins" about the apparatus. Personally, I was very timid about operating it in the beginning. The difficulties which have been enumerated never have to be thought of now because the present instruments are built small, about the size of an average suitcase, with all these relations between the various parts made permanent, and instead of being placed upon a stationary foundation to avoid any extraneous vibration, they can be carried about at will.

The galvanometer fibre, or string, mentioned in the above discussion was very fragile, usually made of quartz and having a metallic coating of either silver or gold. The first ones were silver-coated, which were not so good. Two strings came with the instrument. We managed to put both of them out of function fairly promptly. During the previous year I had become acquainted with Prof. H. B. Williams, the physiologist at Columbia University. He was working with an electrician, building an electrocardiograph and one of his jobs was to make these strings. I asked him if he would make one for us. He demurred, and said that he

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didn't believe he had better try it. I, however, coaxed him and he finally agreed to make a string and it lasted for more than two years' subsequent work. His method of making these fibres was interesting. He would first fuse some quartz. He had a crossbow put up in his laboratory and attached the fused quartz to the arrow and to the projector, then shot it across the room. That would draw out the fine fibre, so fine that only in a suitable light could it be seen, which he would then have to hunt for. When found, a segment of it was placed in a proper vacuum and bombarded with gold, literally plated with gold, so that it would conduct a current, the naked fibre being a nonconductor. The silver-coated fibres which we had originally obtained with the apparatus had not proved durable and Prof. Williams afterward said the reason he didn't want to make one for us was that he thought it would be broken right away and his fibres would be in disrepute.

In those days, to make the procedure of obtaining records even more complicated, the method followed was to have a patient sitting in a chair with the left foot and both hands individually immersed in saline solution in large earthenware vessels. These vessels contained small porous pots in which zinc electrodes were immersed in a chemical solution and had wires attached to them and to the instrument. This device took the place of the small electrodes now attached directly to the patient's extremities. It was efficient but extraordinarily clumsy and troublesome.

The first help was a lucky find. The instrument was installed just about the time of the annual examination of graduates for internship for the coming year. There were some twenty or more, among them Harry Clough of the Johns Hopkins Medical School. It was my good fortune that he drew the date for his internship beginning on April 1st, 1916, which made his service begin nine months after his graduation. I sought him out and induced him to come and work for me during that period. The hospital agreed to give him his living. He was an expert amateur photographer and had a fairly good mechanical turn of mind, in addition. He produced beautiful records. I think all of the tracings I had seen up until then were taken on films which were developed and then had prints made from them. Just about that time there was put on the market a bromide photographic paper that was made for the purpose of taking electrocardiograms. I learned in New York from Dr. Williams that it was not regarded as satisfactory; however, Clough tried out the bromide paper and was able to get some fine records, demonstrating that the paper was all right if the proper technique was used, and we soon had a number of letters asking for particulars as to the technique. Some of these records are still on file in the Heart Station in excellent condition. I feel very sure that some of the credit was due to Clough that the paper came fairly promptly into general use.

Because the electrocardiograph as built at that time was unwieldy and in no way portable, patients had to be brought to it to get records. However, it was sometimes desirable to take a record on a patient who was too sick to be moved with safety. It was found that the distance of the patient from the instrument was no obstacle providing that a connecting wire could be taken from the instrument to the patient. To accomplish that, a cable of multiple wires was installed in the walls of the hospital building, from the electrocardiographic room to the various wards. There was also a separate cable containing wires for a telephone connection. A lead wire from the patient was plugged into the cable from a ward outlet and a connecting wire from the instrument attached to another socket in the room where the instrument was. Thus the patient's record could be taken while he lay in bed at varying distances from the electrocardiograph. We learned of this device from the Peter Bent Brigham Hospital in Boston and it was used for years at the Rhode Island. Now, the instrument is easily carried from one patient's bedside to another in any part of the building, so that this distance wiring is no longer in use.

There were many headaches and heartaches associated with getting the records during the period of years between the acquisition of the first instrument and the development of the present day apparatus.

To return to the first year's use of the electrocardiograph, Dr. Clough was so skilful that we had comparatively little trouble in getting records at any time they were wanted, but after the nine months spent working with me he took his two years' internship and when that was finished he wanted to get an outside job. During World War I an Army heart hospital was established at Lakewood, N. J. I wrote to Dr. Theodore C. Janeway, former Professor of Medicine at Hopkins, who was in the Surgeon General's office, and especially interested in this heart hospital, telling him of Clough's experience with the electrocardiograph and asking if they would have any use for him there. The result of that was that Clough went to the hospital and remained there doing the electrocardiographic work until the end of the war. I, myself, visited there for a few days while I was in the Army. Clough had gotten well established in his job and was carrying on very satisfactorily. At the end of the war he returned to his home in Rochester and I think subsequently was in the physiological department in the medical school rather than carrying on the practice of Medicine. He died a few years ago.

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EXPERIENCES WITH THE INTRA-ARTICULAR USE OF HYDROCORTISONE ACETATE

A. A. SAVASTANO, M.D.

The Author. *A. A. Savastano, M.D., of Providence, Rhode Island. Senior Orthopedic Surgeon, Miriam Hospital; Assistant Orthopedic Surgeon, Rhode Island Hospital.*

ALTHOUGH I have used hydrocortisone in many cases of acute bursitis with or without calcium, tenosynovitis in various locations, epicondylitis, ganglia, and many other conditions, this paper will be limited to my experiences with the intra-articular use of hydrocortisone acetate.

The chemistry of the synovial fluid, the pathological and X-ray changes which take place in the various forms of arthritis, and the diagnostic signs and symptoms have been well described in other papers; therefore, these will be omitted in this presentation.

Over the years, the medical profession has tried many types of intra-articular substances to reduce inflammation in arthritic joints. These have consisted of sterile preparations included among which are iodized oil, procaine, and petrolatum. None produced any appreciable satisfactory effect until hydrocortisone came into being. Doctor George Thorn is given credit for first injecting compound F or hydrocortisone into an arthritic joint and noticing not only a local improvement, but a systemic amelioration. The general improvement of the patient was such that it caused the local anti-inflammatory value of the drug to be obscured at least for the time being. Since Doctor Thorn's first experience with the intra-articular use of hydrocortisone, many papers have appeared in the literature relating the experiences and results obtained by the use of the drug. The reports to date indicate uniformly favorable results. To this long list of reports, I wish to add my general experiences and observations gained in the treatment of a goodly number of cases with joint pain resulting mostly from osteoarthritis, rheumatoid arthritis, traumatic arthritis, and gout. The material reported is entirely from my private practice.

Ten hundred and seventy-two patients have been treated and given a total of six thousand four hundred and thirty-three injections. Some of the patients have received only one injection while some have received as many as fifteen injections over a period of approximately thirty-one months. The average number of injections per patient was approximately six. Of the total number of patients, eleven had acute gout, thirty-nine had traumatic arthritis which followed fractures extending into joints, and the remainder had either osteoarthritis or rheumatoid arthritis.

Technique Used

The commonly used office technique was followed in every case without the use of sterile drapes or sterile gloves. All needles and syringes were autoclaved. The hands were washed with soap and water and the area to be injected was also washed with soap and water and then sponged with alcohol. Novocaine was used for the first few months, but as I became more experienced with the aspiration of each specific joint the use of novocaine was abandoned. As time went on, it became increasingly apparent that the patient had no more pain when novocaine was not used than when it was used. In each case, if any excessive amount of synovial fluid was present in the joint it was aspirated prior to the introduction of the hydrocortisone. It was immediately observed that the patients who had distended joints aspirated obtained immediate relief. This improvement, however, was felt to be due to relief of pressure from the removal of excessive fluid rather than to any immediate effect of the hydrocortisone. The amount of hydrocortisone introduced into the joint was dependent upon the size of the joint injected. The larger the joint the more hydrocortisone injected. Never was more than 2 cc. injected and never was less than 0.25 cc. injected. In each case 25 mg. hydrocortisone equaled one cc. of the drug.

The average dose of hydrocortisone injected into the various joints was as follows:

Joint	Dosage
Temporomandibular Joint	0.5 cc.
Acromioclavicular Joint	0.5 cc.
Sternoclavicular Joint	0.5 cc.
Shoulder Joint	1 cc.
Elbow Joint	1 cc.
Wrist Joint	.5 cc.
Metacarpophalangeal Joint	0.25 cc.
Interphalangeal Joints	0.25 cc.
Hip Joint	1 cc.

continued on next page

Knee Joint	1 cc.
Ankle Joint	1 cc.
Metatarsophalangeal Joint	0.5 cc.

Following the injection of the drug, the needle is withdrawn and the point of entry of the needle is again sponged with alcohol, dried and a band-aid applied. An ace bandage is used as a compression on the knee if a considerable amount of fluid is aspirated prior to the injection of the drug. Not a single infection occurred in the 1,072 cases reported.

The technique which was followed by me and by and large recommended by Doctor Hollander for the injection of the various joints was as follows:

1. *Knee Joint.* The needle is inserted from the middle of the medial or lateral side of the patella and the needle is directed posteriorly and laterally or medially as the case may be.
2. *Hip Joint.* The needle is started anterolaterally at about the middle of the junction of the neck of the femur to the trochanter. The needle is directed superiorly and medially. When the needle passes through the capsule, one gets the same feeling or sensation as he does when he enters the spinal canal when doing a lumbar puncture.
3. *Shoulder Joint.* The needle is inserted between the tip of the acromion and the head of the humerus with the needle being directed downward and medialward.
4. *Acromioclavicular, Temporomandibular, and Sternoclavicular Joints.* The needle is inserted straight into the joint. These joints are rather easy to enter as the examining finger can generally feel the joint space.
5. *Wrist Joint.* The needle is inserted just distal to the end of the radius on the dorsal side and straight into the joint.
6. *Elbow Joint.* This may be entered posteriorly just proximal to the upper portion of the olecranon with the elbow flexed at right angle or it may be entered laterally.
7. *Ankle Joint.* The needle is inserted into the anteromedial aspect of the joint just above the level of the tip of the internal malleolus.
8. *Metacarpophalangeal, Metatarsophalangeal, and Interphalangeal Joints.* The needle is inserted on the lateral side of the joint.

In each case, a 20-22 mm. gauge needle was inserted on an empty 2 cc. or larger syringe. If fluid was present in the joint, it was aspirated. Then, hydrocortisone was loaded into another syringe through an 18 mm. gauge needle and injected into the joint through a smaller gauge needle which is already in place. The needle was withdrawn, the puncture hole was sponged with alcohol, dried, and a band-aid applied.

Mode of Action of Hydrocortisone

The mode of action of the injected drug is still essentially unknown. Hollander has reported that the injected microcrystals of hydrocortisone disappeared within two hours in the synovial fluid of joints and made their way into the lining cells of the synovial membrane where they are retained. Hollander further is reported as concluding that hydrocortisone is about $\frac{1}{7}$ as soluble in plasma as cortisone and, therefore, may derive its anti-inflammatory qualities by remaining in the local area longer. Hollander and his group have reported the results recently obtained on the intra-articular use of hydrocortisone tertiary-butylacetate on 92 patients with knee rheumatoid arthritis and 79 cases with knee osteoarthritis. The difference between the hydrocortisone tertiary-butylacetate and the hydrocortisone acetate is that the butyl acetate type is supposed to be less soluble than the hydrocortisone acetate; however, no real appreciable difference was noted in the results obtained when the drugs were used separately on similar cases.

Observations

The first and most important observation made was that hydrocortisone did not produce complete relief in all cases, and in some cases no relief whatever was obtained, while in other cases the pain was made worse. It has been said many times that the cases which become worse following the injection are due to the drug being injected inadvertently extra-articularly into the soft tissues. I do not consider this statement to be entirely true as a certain number of my cases became worse even when ten or more cc. of synovial fluid were removed from the knee joint prior to the injection of the hydrocortisone. In these cases, there was no question at all about the drug being injected directly into the joint proper. Also in these cases, the reaction was such that the additional pain could not possibly have been due to seepage of the drug and synovial fluid into the soft tissues through the puncture hole as in most cases the gauge of the needle used was quite small. In these cases, the pain and swelling if there was any, increased within two hours following the injection and the joint became warmer. The patient reported the reaction in most cases two to five hours after the injection. All of these cases cleared up within 24-48 hours with rest of the joint, mild sedation, and the application of cold compresses. Not a single infection occurred in the entire series.

Generally, however, the observations have been that there is an improvement which starts from a few hours to a few days after an injection and has lasted from a few days to many months. One patient has had no discomfort in her knee for thirty-one months following one injection for moderately severe osteoarthritis which was easily demonstrated by X ray. The over-all picture has been that ap-

proximately 8.5 joints out of every 10 injected have improved. The patient generally reports a decrease in pain, a decrease in stiffness of the joint and an increase in motion. Any one or any combination of these improvements may take place. It was observed that the longer a swelling had existed the less this was affected by the hydrocortisone. It was previously mentioned in this paper that any improvement which came about immediately following the aspiration of a joint was felt to be due to the release of pressure rather than to any immediate effect that hydrocortisone might have on the joint. The sedimentation rate of the blood was taken and complete blood counts and urinalysis were done on the first several cases of rheumatoid arthritis treated by this method, but no appreciable change took place even when a definite marked improvement of the symptoms took place. Injections were given at weekly intervals when deemed indicated. The injections were not repeated in cases where complete or marked relief was obtained. These patients were asked to return only when and if the symptoms recurred. If the patient obtained improvement but still had annoying symptoms, injections were repeated at weekly intervals until either marked improvement resulted or the injection was stopped because it was felt that it would be futile to continue the treatment. In cases where no relief whatever was obtained, the dose of the subsequent injection was doubled, but more than 2 cc. of hydrocortisone was never injected into a joint. If the larger dose did not produce the desired effect, no further injection was given. Repeated injections at varying intervals on joints previously improved had either the same effect or a better effect for even longer periods of time. In this series of cases, adjunct systemic therapy was used whenever deemed indicated. This included mild splinting, heat, codeine, aspirin, anti-gout drugs, and etc.

In the 1,072 cases treated, no case has been included which has not been followed for at least three months since the last injection. Of the total group, 267 or approximately 25% obtained so much relief after one to three injections that no further treatment became necessary for three months or longer. This group includes some cases of gout and traumatic arthritis. 643 patients or approximately 60% obtained temporary relief and have maintained their relief by periodic injections of from one month to three months. The remaining 162 or approximately 15% can be considered as failures as they did not improve after one single and one double dose of hydrocortisone.

Not included in the above statistics are some observations which were made when hydrocortisone was put into knee joints at the time of surgery. Your essayist has used hydrocortisone in 24 knee arthrotomies done for the removal of torn cartilages and has observed that these joints showed less post-operative swelling and had less pain than did similar cases where hydrocortisone was not used. Wound healing was not affected. In each case, 2 cc. or 50 mg. of hydrocortisone was put into the joint immediately prior to closure of the wound.

CONCLUSIONS

1. 1,072 patients have been treated and have received a total of 6,433 injections of hydrocortisone acetate for an average of six injections each.

2. Approximately 85% of osteoarthritic and rheumatoid joints were improved by the injection. 100% of gouty joints were improved and about 89% of traumatic arthritic joints were improved.

3. A small number of cases were either not helped or were made worse by the injection.

4. The sedimentation rate and blood count did not seem to be affected by the intra-articular use of hydrocortisone acetate.

5. Hydrocortisone did not seem to have any appreciable effect on the production of excessive fluid in a joint.

6. The improvement reported generally consisted of decrease in pain, decrease in stiffness and increase in motion.

7. Hydrocortisone has a definite place in the treatment of selected cases of arthritis.

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CHRONIC GRANULOMATOUS ILEITIS AND JEJUNITIS*

The Dr. Isaac Gerber Oration

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ALTHOUGH non-specific granulomas of the gastrointestinal tract had been recognized previously, it was not until 1932 that Crohn, Oppenheimer, and Ginzburg[1] described the pathologic changes, symptoms and treatment of a sub-group which they called "regional ileitis." Since their communication, other significant observations have been reported. It soon became apparent that in addition to the terminal ileum, the granulomatous process involved either separately, or in combination, the cecum,[2] other parts of the colon, the jejunum, the ileum, and occasionally the duodenum and the stomach.

This presentation will be concerned solely with the subject of chronic granulomatous regional enteritis. It will not discuss this disease either in conjunction with coincidental simple chronic ulcerative colitis, with chronic granulomatous colitis, with localized colitis in the region of an enterocolostomy, or the ileitis which occasionally follows a colectomy for ulcerative colitis.

Etiology

No cause has been definitely established, although many pathologic conditions and agents have been suspected such as specific bacteria, bacillary dysentery, protozoa, viruses, sarcoidosis, trauma and hereditary factors. Janowitz[3] aptly states, "speculations regarding the pathogenesis of the disease process should be rooted in the known facts of the natural history of the disease. Three such facts are paramount. (a) The vast majority of patients have the initial lesion in the terminal ileum. (Up to 80% in some.) (b) Diversion of the fecal stream by short circuiting operations leads in the majority of instances to regression of the process in the excluded areas of the intestine. (c) Recurrent lesions in the overwhelming number of cases are again localized in the new terminal ileum. These facts suggest that the noxious agent is present in the intestinal stream. They also suggest that the agent or agents may be water soluble, may be concentrated as the intestinal contents are propelled through the small bowel, and may become absorbed by the lymphatics of the ileum which are so rich in the region of the ileocecal valve. Here they may set up their characteristic proliferative sclerosing endolymphatic reaction."

Pathology

Chronic regional ileitis is characterized by a submucous necrotizing and cicatrizing inflammation. While the disease seems to have a predilection for the terminal ileum and may end there abruptly, it may involve any area of the small bowel segmentally or diffusely. Grossly the serosa of the bowel is red, congested and often covered with exudate. Its walls are extremely thickened, edematous, leathery and rigid. Various segments of the intestine may be grossly involved by "skip areas" separated by areas of normal bowel which are usually dilated. The corresponding mesentery is usually edematous, and rigid, and the lymph nodes are inflamed and definitely enlarged. Upon opening the intestine, the normal mucosa is altered and may have a granular cobblestone appearance. This is due to linear ulcers usually parallel to, and mainly along the mesenteric border. These ulcers often penetrate into the submucosa and muscularis forming abscesses which are responsible for fistulous tracts. The latter may form between adjacent loops of bowel, the colon, the rectum, the ureter, the bladder, fallopian tubes and the vagina.

A fistula to the anterior abdominal wall may develop subsequent to either an appendectomy or the spontaneous rupture of an abscess from an unrecognized ileitis. More rarely, the abscesses may point retroperitoneally in the inguinal or the lumbar region. Rectal or recto-vaginal fistulas, which are quite common, may result from the devious tracting of infection from the small intestine. It should be remembered, however, that an infection of the crypts of Morgagni due to a diarrhea may result in ischiorectal abscesses.

*The 8th Annual Dr. Isaac Gerber Oration, delivered at Miriam Hospital, Providence, Rhode Island, October 19, 1955, under the sponsorship of the Miriam Hospital Staff Association.

The microscopic appearance which is not pathognomonic, consists of acute, subacute and chronic inflammation.

According to Otani,[4] there are extensive collections of plasma cells and lymphocytes in the submucosa. The muscularis is hypertrophied and inflamed, the latter process extending to the serosa, and the fat tissue around the intestine accounting for the segmental thickening of the intesinal wall. Multiple small epithelial tubercle like nodes with occasional giant cells can be seen in the submucosa musclar layers, serosa and fat. Some show central necrosis, some suggest caseation, but the presence of tubercle bacilli have never been found. Healing and scarring of the ulcerated areas may also be seen, and these isolated areas which become hypertrophied are polypoid in appearance. The lymphatic infiltration in the submucosa and serosa often form lymph follicle arrangements.

Symptomatology

The disease is widespread geographically. It has no predilection for either sex or age group, and may even affect children. It is occasionally seen in an acute phase at which time a diagnosis of appendicitis may be made. At operation, the terminal ileum may be acutely inflamed and the appendix involved by contiguity. We now know that the removal of the appendix may lead to a persistent fecal fistula and that these cases when treated conservatively, usually subside. If symptoms persist, operation may be performed at a later period.

While there are instances in which chronic ulcerative granulomatous enteritis may be so insidious in onset that it produces no symptoms until late in the disease, patients usually give a history of general malaise, loss of weight, easy fatigability, diffuse abdominal discomfort, a mild diarrhea, and often discharging perirectal sinuses. As the diarrhea increases, colicky pain develops, occasionally with the development of intermittent intestinal obstruction, although this is rarely complete. The diarrhea is usually mild, the stools being liquid or semi-solid, often with mucous and may contain occult blood. More rarely the first intimation of the disease may be a severe melena or the sudden appearance of a cloudy, foul smelling urine, or an odorous vaginal discharge. In other instances there may be no abdominal complaints, just a persistent low-grade temperature, which is often ascribed to rheumatic fever, or possibly an endocarditis. In other cases with definite bowel symptomatology, high septic types of temperature and chills are seen. A secondary anemia of the hypochromic microcytic type is invariably present. Physical examination may disclose, in addition to anemia, loss of weight and low-grade fever, the presence of external fistulae, or an abdominal tumor. The site and number of the external sinuses may vary as does the location of the mass which may be palpable in the right lower quadrant, or by rectum or vagina.

Roentgenologic Findings

These have been described by Sussman and Wachtel,[5] and more recently by Wolf and Marshak.[6] They shall be only briefly outlined. Initially, in the acute stage, examination of the small intestine may reveal in any area, only an alteration of the mucous membrane pattern which is indistinguishable from avitaminosis and sprue. In the subacute and chronic stages leading to stenosis, the findings are more characteristic because there is rigidity of the bowel with narrowing and a loss of mucous membrane pattern. Large inflammatory polyps may be seen occasionally. Skip areas of the disease alternating with dilated loops of intestine are characteristic. The pipe stem appearance of the terminal ileum called the "string sign" is pathognomonic of the disease. This is due to irritability and spasm of the bowel with marked ulceration. Fistulous tracts, characteristic of ileitis, may frequently be demonstrated.

In jejunoileitis, skip areas are fairly common, but fistula formation is less frequent. Those cases in which the jejunum alone is involved are apt to be characterized by a marked stenosis with extreme dilatation either of the proximal bowel, or the bowel between the skip areas.

Diagnosis

As a rule this is not difficult. Yet it is amazing how frequently in the face of an obvious symptomatology, X-ray examination is not performed and the patients are treated either as psychoneurotics, or are regarded as having a simple diarrhea or mild colitis. In a boy of thirteen with mild gastroenteric complaints, the condition was regarded as neurosis. He was treated by a psychoanalyst for four years until vomiting and signs of an intestinal obstruction developed. X rays then revealed a localized jejunitis. Atypical forms of the disease may be baffling and there are instances in which amaebic dysentery, idiopathic colitis, abdominal Hodgkin's, lymphosarcoma and sarcoidosis, as well as from tuberculosis, which must be eliminated. Ordinarily, however, the presence of a mild diarrhea with abdominal cramps, fever, and the presence of an abdominal mass or rectal fistulae, should be sufficient to make one suspect the presence of regional enteritis which subsequently may be substantiated by X-ray examination.

Treatment

The enthusiasm twenty years ago for immediate surgical intervention as a definite cure for this disease has gradually been dispelled by the rising incidence of recurrences following surgery. A

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clinical history confirmed by the X-ray diagnosis of regional ileitis does not necessarily mean surgical intervention. We know that the disease may remain stationary with a paucity of symptoms, and occasionally even diffuse jejunoileitis has been known to spontaneously disappear. Unfortunately there is no specific medical treatment and antibiotics and cortisone are of dubious value. But some patients do respond to supportive treatment consisting of rest, a high protein diet with adequate carbohydrate, vitamins and blood transfusions and may go for years with little alteration in their physical condition. However, if there is a progressive loss of weight, a debilitating diarrhea, cramps with partial intestinal obstruction, persistent temperature, palpable masses with draining fistula, operation becomes mandatory.

Prior to surgery, however, these patients should be adequately prepared. If necessary, parenteral fluids and blood should be administered. The usual bowel preparation with intestinal antibiotics is prescribed, but cathartics are carefully given. The fact that loops of bowel may be matted together by dense adhesions and fistulous tracts, and partially obstructed, makes intestinal intubation advisable a few days prior to operation. The long tube not only effectively decompresses the bowel, but the tip of the tube points distally affording identification of the proximal bowel.

We employ spinal anesthesia routinely. A lower right rectus muscle splitting incision is usually made unless roentgenologic examination reveals isolated pathologic changes high in the left upper quadrant. The entire bowel is examined from the ileocecal junction proximally. The severity, extent, the location of the disease, and the presence of fistulae are noted. The question then arises as to whether a resection or simple side-tracking of the diseased intestine should be performed. Originally in cases of terminal ileitis, I routinely resected the involved ileum and part of the colon and restored continuity by a side-to-side ileotransverse colostomy. At that time the mortality was appreciable. In order to lower it, a two-stage operation seemed indicated. At the primary stage only an ileal division with ileocolostomy was done leaving the resection for a later period. However, after the first stage, following the defunctionalization of the diseased area, most patients gained weight and lost their symptoms, the inflammatory mass disappeared, and the discharging cutaneous fistulae, if present, healed rapidly. It seemed that resection could be definitely postponed. In 1939, Ginzburg, Sussman and I[7] reported nineteen cases in which a satisfactory result was obtained by this simple procedure. Since then it has been the operation of choice.

The technique of ileal division and ileotransverse colostomy is simple. However, there are some fundamental principles which must be rigidly followed. If the terminal ileum is the seat of the disease, the intestine should be followed in an oral direction until one is reasonably certain that the bowel is divided at least 60 cm. proximal to the last visible skip area of disease. It is granted that areas of incipient disease cannot always be recognized at the time of operation because the mucosal and submucosal lesions are often so small that they defy manual or visual detection. Therefore it is advisable to take a biopsy of the proximal ileum which is to be used for anastomosis for immediate frozen section. The examination may reveal microscopic evidence of acute and chronic granulomatous changes. This added precaution may diminish but does not completely eliminate the incidence of recurrence in the proximal ileum.

When many feet of bowel are to be excluded, it is extremely important to constantly bear in mind which end of the divided ileum is distal, and which is proximal. A double check should always be made to insure the anastomosis of the proximal ileum to the transverse colon. I have seen some tragic mistakes made due to carelessness in this regard. The proximal bowel is sutured to the midpart of the transverse colon isoperistaltically, preferably using side to side anastomosis. The anastomosis should be wide in length so that if a proximal ileal recurrence takes place, the stoma will not be obstructed completely. Care should be taken so that there is no blind pouch of ileum left protruding beyond the anastomosis because this cul de sac will gradually dilate, often to such dimensions as to cause disagreeable abdominal symptoms.

If the disease is extensive the question arises as to how much small intestine can either be side-tracked or resected with safety. We have read occasional reports that following massive resection for superior mesenteric thrombosis in which only a foot and half of the jejunum remained, the patient survived. Similar cases have been reported after resection for jejuno-ileitis, but from my own observation many of these patients finally succumb from the effects of malnutrition.

There is no way in which one can judge in a particular case how much intestine must be preserved so as to insure life. Patients vary greatly in their ability to maintain adequate nourishment following massive resection. I have one patient, who following a series of resections, now only has 40 inches of proximal jejunum. He is perfectly well and maintains his weight. However, I have another patient in whom I did a primary side-tracking of many feet of ileum and an extensive recurrence developed. At the time of the second operation, after excluding the disease only three feet of jeju-

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WHAT'S AHEAD? POLITICS, TAXES, AND SOCIAL SECURITY

THERE ARE UNDOUBTEDLY thousands of physicians to whom the Congressional bill H.R. 7225 means little or nothing today. Every physician will know plenty about the bill, under that catalog number, or any other number, before the year 1956 is far on its way.

There are millions of taxpayers of the country who are ignorant of the costs for, or in the first instance the need for, revisions to the Social Security System as proposed during the current session of Congress, and passed under a "gag rule" by the House of Representatives with no public hearings and a limited forty minutes of debate on the House floor. These millions of taxpayers must be informed fully, and clearly, of the implications in the proposals that will be renewed in Washington next year, and the information must be devoid of the emotionalism and political flag waving that characterized the discussion in the House of Representatives last July.

Passed by the House, and now to be heard and debated by the Senate, House Bill 7225, the Social Security Amendments of 1955, would provide:

1. Payment of monthly benefits at or after age 50 to workers who are totally and permanently disabled.

2. Lowering the retirement age for women to 62.

3. Continuance of monthly benefits to children who become totally or permanently disabled before age 18.

4. Expansion of old-age and survivors insurance coverage to the self-employed professional groups now excluded—except physicians—and to certain farm owners.

5. An increase of the tax rate on employers and employees by one-half per cent, and three-fourths per cent on the self-employed, effective January 1, 1956.

Aside from the tremendous potential tax burden that the continued expansion of the Social Security System will place upon every taxpayer, the medical profession has great additional concern regarding the further invasion of the Federal government in the realm of medical care.

A worker must be unable to engage in any substantial gainful activity, by reason of any medically

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determinable physical or mental impairment which can be expected to result in death or to be of long continued and indefinite duration. A waiting period of six consecutive months is required before a worker would be eligible for benefits. This in itself presumably lends an appeal to the next step in the socialization plan—temporary disability benefits while waiting the determination of total disability, with the physician, pressured by patient and federal agency, the key figure in the issue even though he is ignored in the legislative planning.

If anyone has any doubts that the Federal Social Security System, offering as it does some income for millions of people in their later years, is not being used as one of the most powerful weapons of political bodies and their leaders to get and retain themselves in power, a reading of the limited debate on the legislation in the Congressional House of Representatives last July will readily dispel it.

Consider some of the emotional generalizations voiced on the floor in the forty-minute "gag rule" debate on these proposals that would saddle the American people with additional billions of dollars taxation. Hear you this:

> "What right-thinking person can argue against extending coverage to disabled children over 18 whose deceased parent has helped to pay for such coverage, or workers disabled at age 50?"
>
> "Understanding the problem that women over 35 years of age have today, in seeking employment, how can anyone deny them old-age or survivor's benefits at age 62? . . ."
>
> ". . . The lowering of the benefit age for women to 62 years of age is a step in the right direction, but 10 years ago I advocated the lowering of this age . . . to 60 years. . . ."
>
> ". . . We still place a limitation on when a beneficiary can actually receive total and permanent disability benefits . . . at 50 years. . . . If we are to have total and permanent disability . . . (it) . . . should be made effective for all those covered by Social Security at the time it occurs, be it age 50, 40, or 35 years. . . ."
>
> "Another and important amendment which I have been sponsoring over the years, and which will eventually become law, provides 60 days of free hospitalization for all recipients of Social Security benefits. . . ."

Step in the right direction? Better face it. The politicians aren't stepping, they are running to see who can give away the most benefits, each confident that he will not be around at the future date when the succeeding generations cry out against the unjust tax burden piled on their shoulders when they were babies. But who cares about taxes today, especially when a "bargain" is involved, infers one of our Congressmen who said:

> "I am firmly convinced that upon enactment of the pending legislation, H.R. 7225, the Social Security System will be actuarily sound. The tax increases proposed in this bill seem heavy to many people. They are substantial. Yet they are necessary to preserve the soundness of the trust fund, and where can anyone obtain so many benefits for so low a price? . . ."

Who says the system is sound, and the proposals good ones? Industrialists, insurance authorities, professional leaders, actuaries? *No.* Just the Social Security "experts"—experts in socialization, certainly—for the record relates:

> "Mr. Speaker, any impression that this bill has not been thoroughly and adequately considered is simply not a statement of fact. This bill was considered in executive sessions of the Committee on Ways and Means with the experts of the Social Security Board present every day in at least 15 to 20 meetings. . . ."

Perhaps by now you are wondering if your Congress knows of the work done by the states, by private and public agencies to care for the needy, the unfortunate, and the disabled. Cease wondering, and note how subtle is the memorandum on House Bill H.R. 5057, a bill to provide disability insurance, wherein public assistance and public charity, keystones of our democratic system, are categorized as "public dole" with the offensive connotations that term carries—

> "Many income studies conducted during recent years point out that disability and low income go hand in hand in many instances. These studies point out that among urban families in the low-income class one of the chief causes of poverty was traced to the disability of the head of the family.
>
> "Other studies also show that disability accounts for a very large portion of public relief expenditures. This also applies to private charity which helps an additional number of disabled persons.
>
> "By providing a systematic program of social insurance against a disability, it would be possible in time to reduce the need for relief and public dole. . . ."

With medical care and rehabilitation of the disabled paramount issues, you are certain that experts in those fields were on hand when this vital legislation was reviewed with the Social Security "experts." But were they? Not according to the *Record*—

> ". . . Our states and private enterprise, and indeed, the Federal government, have made tremendous strides in the field of rehabilitation. Any disability program must be carefully geared

into the rehabilitation programs. . . . No person in the rehabilitation field was even called before our Committee to discuss the matter. . . ."

Surely some of the members of Congress resented the tactics carried out in July; undoubtedly many felt as the member who stated:

"Now here today, if you please, supposedly I am jockeyed into the position of either voting for this improperly conceived or studied bill in its entirety or of being branded as one not interested in the welfare of my fellow man. Now does anyone here deny that that is the essence of the procedures followed by our leftwing political element who have so long and too long, in my judgment, dominated American political thinking. Either you agree with their brand of government or you are against the people, against the little man. . . ."

How, then, did this legislation ever pass the House of Representatives without public hearings, and without unlimited debate on the controversial issues involved? Was it a face-saving gesture as indicated by one Congressman who said:

"The matter before us today is just incidentally the subject of Social Security. The real matter before us is the reputation of the Ways and Means Committee, and the reputation of the House of Representatives. . ."

Or was it not less in the interest of public welfare and more in the interest of political control in 1956, as indicated by the statement that:

"The 2.8 million additional beneficiaries that will eventually become eligible for benefits under these liberalizing amendments warrant the support of the Republican members of the House, as well as the Democratic members. . . ."

What's ahead? What do the advocates of individual responsibility for one's own welfare need to do to put a stop to this unwarranted abuse of the taxing power of government?

A. L. Kirkpatrick, writing in the publication AMERICAN ECONOMIC SECURITY offers this thought-provoking answer—

". . . To put it broadly, it seems obvious that we need to reorganize our ranks, review both our offensive and defensive strategy and to launch an action program aimed to awaken a sleeping population to what is going on largely unknown to it. At least many people appear to have no conception of the long range implications and cost of the program that is being gradually projected upon them.

"We are living in what Sir Winston Churchill might call an attempted state of 'peaceful co-existence' with the welfare pressure groups, with the forces which are seeking to make the individual subservient to government. But Sir Winston also pointed out that any attempt at 'peaceful co-existence' with aggressors must be 'vigilantly guarded.' The businessmen of the country, years ago, accepted our national old age and survivorship program as a basic part of our economic system, on the promise that its benefits should be kept at a 'minimum level.' In the light of the pressures which have developed for more and higher benefits and the relative ineffectiveness of the resistance to the expansion, many are now wondering if they made a mistake in agreeing to 'peaceful co-existence.'"

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num remained to anastomose to the sigmoid. She ran downhill and months later she was explored. The excluded bowel attached to the transverse colon now appeared grossly normal so that I took down the jejunosigmoidostomy and restored the continuity of the bowel. Following this there was a reactivation of the jejunoileitis. Fortunately for the past ten years she has been successfully maintained by rest in the hospital with blood transfusions and special diets high in proteins.

Massive resections are to be avoided whenever possible. It is better to be less radical and resect localized areas of jejunal disease with a side to side jejunostomy.

While the side-tracking procedure is our first choice, there are indications for resection. This becomes necessary when there are fistulae between the ileum and the sigmoid, or ileal disease has produced areas of extreme stenosis. There are also objections to ileostomy with exclusion. In our experience the fear that sufficient intraluminal pressure might endanger the suture line of the excluded ileum has not been substantiated. Nor have we ever witnessed ulceration with perforation from the pressure of stercoraceous masses accumulating in the blind colic loop. For retrograde peristalsis is present in the colon normally, and when an impulse is received distally, the colon responds by emptying itself in the usual direction.

It was also predicated that in cases in which the ileosigmoidostomy was performed, the emptying of the fluid contents of the ileum might irritate the sigmoid and rectum and produce diarrhea. This has not been observed in any case in which the sigmoid was found to be normal at the time of operation. As a matter of fact the diarrhea which was previously present has disappeared in every case of right-sided colitis and ileitis. In a number of instances, previously discharging perianal fistulas healed instead of becoming aggravated.

In a number of instances, post-operative studies were made with barium enema. These showed no abnormal dilatation or distention of the bowel and the excluded colon and the haustrations and sacculations were normal even after years of unilateral exclusion. When a barium enema is administered, there is, as a rule, retrograde passage through the ileocolic stoma as well as into the excluded bowel. Moreover the force of barium is sufficient to carry the contrast medium to a point much farther than occurs ordinarily by retrograde peristalsis.

At the conclusion of either an exclusion or resection procedure, the abdomen is closed without drainage. The intestinal tube is retained until peristalsis returns as evidenced by the passage of gas and feces by rectum. In a collected series,[8] the mortality rate for resection was 11.2%, and for side-tracking 4.6%.

Post-operatively most of these patients do well. Their appetite returns and they gain weight. The stools become soft in consistency and movements occur about three times a day without cramps.

Recurrences

Unfortunately, however, there are some patients who do not remain well. Many patients within a few months to a year have a return of all symptoms for which they sought relief. In others the duration of the symptom-free interval after primary operation for regional ileitis can be surprisingly long. This is illustrated by cases in which the patients remained well for more than fourteen years before a recurrence was manifested clinically. Freedom from symptoms does not necessarily mean eradication of disease. In one case, recurrence was demonstrated by roentgenologic examination after nine years of complete well-being. Despite this, the patient remained well clinically for five more years. In another case, persistent disease in an excluded loop was eradicated by resection after twelve symptom-free years. This procedure was followed by an asymptomatic proximal recurrence which has lasted two years to date. There is one case which deserves special mention. The patient had all the complications of regional ileitis, namely peritonitis, intestinal obstruction, abdominal mass and fecal fistula. In six years he underwent seven major operations for his disease. A "cure" was obtained by secondary ileal division with ileosigmoidostomy, and he has remained well for the past seven years.

The incidence of recurrence in regional ileitis is much more frequent than was originally reported, and it would appear that this will increase in direct proportion to the length of time that the patients are followed. The recurrence rate was about 29 per cent in 781 cases collected from the literature in which a simple occlusion operation was performed and 21.8 per cent in 2,209 cases in which resection was performed. The type of surgical procedure, therefore, appears to have little influence on the ultimate course of the disease. Clinical experience seems to indicate that the fate of the patients depends upon whether or not the disease is definitely localized and remains localized to a comparatively small segment of terminal ileum in which the disease has been completely resected, or completely side-tracked.

Most recurrences are noted in the proximal ileum at the site of the anastomosis. Many of these are undoubtedly due to skip areas of disease which defied detection at the primary operation. It is these foci which undoubtedly account for the early further extension and progression of the disease. It is difficult to explain the very late recurrences on

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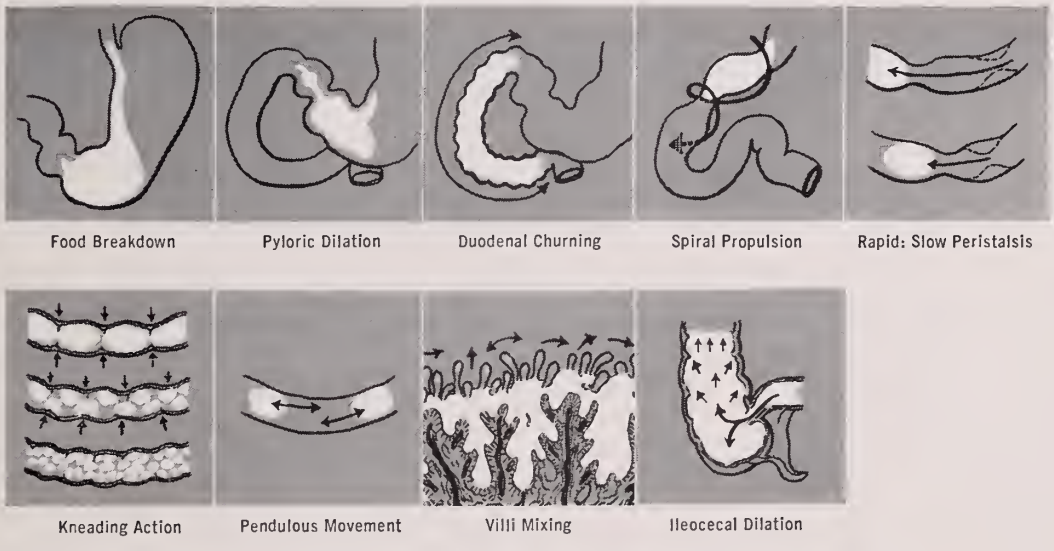
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TYPES OF MOVEMENT WITHIN THE BOWEL



SEARLE

CHRONIC GRANULOMATOUS ILEITIS AND JEJUNITIS

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this basis for it is unlikely that skip areas have remained dormant for ten to fifteen years.

It would appear more logical to postulate that the unknown factors which originally caused the disease and were altered by the surgical procedure may again have become potent. The presence of an active or dormant lesion in an excluded distal portion of the ileum probably plays no part in this type of recurrence. It is unlikely that the defunctionalized bowel acts as a focus from which the disease can travel via the mesenteric lymph vessels to involve the proximal bowel at or near the site of the enterocolostomy. Exploratory inspection of the excluded ileum and examination of the defunctionalized area resected at a second stage, usually shows that the disease has undergone regression or healing after complete diversion of the fecal content.

On the other hand, it cannot be denied that persistence of the disease in an excluded ileum does occur. In such cases, further ulceration from areas of disease in the side-tracked ileum may lead to fistulous communications with other intestinal loops, the sigmoid and rectum. This is a serious complication of enterocolostomy with exclusion and one of the strong arguments in favor of primary resection in all cases. Nevertheless I do not believe that the unusual instances of persistence of disease in the excluded ileum condemn ileocolostomy with exclusion. Moreover an ileocolic resection may always be done as a second stage procedure if necessary.

The problem of recurrent ileitis therefore, is the treatment of the disease usually in the proximal portion of the small bowel near or at the site of the ileotransverse colostomy. If the symptoms are not severe, patients may be treated conservatively. If surgery becomes necessary, the question again arises as to whether a resection of the diseased bowel, or a second side tracking should be performed.

In cases in which there is a recurrence in the proximal portion of the ileum, after either resection or exclusion, and in which an ileotransverse colostomy has been performed, a second ileal division with an ileosigmoidostomy offers a conservative solution to a complicated problem in which radical operation may become extremely hazardous. It may be technically difficult to separate edematous thickened friable bowel from other viscera and take down the previous anastomosis. Resection of this type of intestine with its thickened, edematous gland-bearing mesentery entails an operative risk. There is ample evidence that the disease in the defunctionalized bowel attached to the transverse colon regresses to much the same extent as it does in the primary excluded ileum. In one case the patient died two and one-half years after ileosigmoidostomy with an ileal division for recurrent ileitis following a primary resection with ileotransverse colostomy. Autopsy revealed that the excluded bowel which measured 27 cm. in length from its anastomosis to the transverse colon was grossly normal and that there was no further evidence of the disease. In another case the patient entered the hospital because of an intestinal obstruction three months after a secondary ileosigmoidostomy with ileal division for proximal recurrence. Exploration disclosed that the acutely inflamed bowel which had been previously excluded was normal in appearance. A barium enema given to another patient two months after a secondary exclusion revealed that the local inflammation at the region of the ileotransverse colostomy had subsided.

Some of these patients, particularly during periods of emotional upset have had frequent bowel movements, but not to a disturbing degree. No symptoms have developed thus far which could be attributed to the presence of the isolated ileal loop which was left attached to the transverse colon.

While surgery in secondary cases in which it is indicated is undoubtedly followed often by another recurrence, the majority of patients are benefited, and many go years before a recrudescence of their disease becomes clinically evident.

SUMMARY

The etiology, pathology, symptomatology, roentgenologic findings, and diagnosis of chronic granulomatous ileitis and jejunitis have been described. The treatment has been detailed, emphasizing that surgery should only be performed for definite indications. A preference for side-tracking ileotransversecolostomy with ileal division rather than resection of the area of the disease was expressed. The question of massive resections for jejunoileitis has been discussed.

The high incidence of recurrence has been stressed, and here too, a conservative method of surgical treatment, if necessary, was outlined.

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CLINICOPATHOLOGICAL CONFERENCE

Presented before the Providence Medical Association, October 3, 1955

MARSHALL N. FULTON, M.D., *Moderator;* JOHN C. LEONARD, M.D., AND THOMAS A. WARTHIN, M.D., *Clinical Discussors;* AND CAMPBELL A. MCNICOL, M.D., *Pathologist*

SUMMARY OF CASE

First Admission

A FIFTY-NINE-YEAR-OLD, white, married school bus driver was admitted to the hospital on March 27, 1953, complaining of fever of one month's duration. His health had been good until approximately four to five weeks prior to admission when he noted symptoms of fever, chilliness, constant frontal headaches, anorexia, and weight loss of at least 10 pounds. He had been treated with chloromycetin, but there had been no favorable response.

Past history was significant for bilateral inguinal herniorrhaphy in 1945, hemorrhoidectomy in 1946, right lower lobe pneumonia in 1949, chronic cough for many years (attributed to cigarettes), and demonstrated duodenal ulcer fifteen years prior with persistent symptoms of belching and epigastric fullness.

Physical examination revealed a well developed and well nourished male in no apparent distress but with the appearance of chronic illness. Temperature 101°, Pulse 92, Respiration 26, B.P. 148 70. Skin, axillae, groins and pubis regions showed hypertrophic hyperpigmented papillae consistent with acanthosis nigricans and scattered seborrheic senile keratoses. Teeth were carious and the pharynx slightly injected. The lungs showed questionable moist rales at the left base and axilla. Heart was not enlarged, the sounds were faint, no murmurs were audible, and A-2 equalled P-2. Abdomen showed questionable tenderness to deep palpation over the entire lower abdomen. Genitalia and prostate were normal.

Laboratory studies—The significant initial laboratory studies showed normal values for glucose and urea nitrogen, negative Hinton, negative agglutinations for typhoid, paratyphoid, Brucellosis and proteus X-19. Examination of the blood revealed: hemoglobin 7.0 grams, RBC 3,000,000, WBC 12,700, polymorphonuclears 83%, lymphocytes 19%, monocytes 8%, sedimentation rate uncorrected 65, corrected 26 m.m. in one hour. Serum protein 6.7, albumin fraction 1.9, prothrombin activity 20%. Urinalysis—specific gravity 1.006, protein 1, sugar negative, RBC 5 to 6, WBC 0-2, and Bence-Jones protein negative. Spinal fluid examination showed 1 WBC, chloride 126, glucose and protein normal.

X-ray examinations — Chest — moderate emphysema; otherwise not remarkable. Paranasal sinuses—normal. Oral films—marked pyorrhea of the upper and lower alveolar ridges. No abnormality was found in the intravenous pyelogram, the barium enema, the retrograde pyelogram, and in the gastrointestinal series. Cholecystogram showed a poorly functioning gall bladder. Electrocardiogram was normal.

Clinical course—During his entire hospital stay the patient ran an irregular spiking fever. The daily excursion usually ran from 100 to 103. He was given successive courses of the following therapeutic agents: dihydrostreptomycin and aureomycin, terramycin, nitrogen mustard and urethane. None of these measures appreciably affected his fever or symptoms.

Subsequent studies during his hospital stay included gastric analysis with a free acid of 65°, a total of 76; repeated blood cultures, all of which were sterile; a bone marrow aspiration which was reported as showing active hemopoiesis with an increase in plasma cells. Initial urine culture revealed a hemolytic staphylococcus. Cultures of the urine obtained at cystoscopy were all sterile. Bromsulphalein test showed retention of 5%. Sternal marrow smear negative for acid-fast bacilli. L.E. cell test, direct and indirect, negative. Serum calcium inorganic phosphorus and acid and alkaline phosphates within normal limits. Stools repeatedly negative for occult blood. Congo red test showed 19% disappearance in one hour. Stool cultures were negative for pathogenic organisms.

On May 11, 1953, an explanatory laparotomy was carried out. This revealed moderate enlargement of the liver and spleen. The remainder of the abdominal organs were palpated and found to be normal. The gall bladder was removed and a liver and muscle biopsy performed. The specimens were reported as showing moderate fatty metamorphosis and pericholangitis in the liver, chronic cholecystitis and a "fragment of striated muscle." Direct laryngoscopy by the anesthetist at the time of operation revealed the trachea to be deviated to the left of the midline. The patient had a moderate drop in temperature following the operation, but this soon resumed its previous febrile level. Following sev-

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eral blood transfusions which did not appreciably affect his hemoglobin level, he was discharged unimproved on the sixty-second hospital day.

Second Admission

Patient was readmitted approximately twelve months after his previous entry on March 13, 1954. In the ten months between admissions his course had been progressively downhill. He had received cortisone with only temporary effect and he continued to have intermittent fever, increasing weakness, weight loss, dyspnea, and constipation. Just prior to admission he had a sudden attack of unconsciousness lasting 30 minutes, following which he became as alert as usual.

The significant findings on this admission were temperature 98.4°, pulse 76, and B.P. 100 62. He was extremely emaciated, pale, dehydrated, and apprehensive. A grade II apical systolic murmur was present, abdomen was negative, and no additional physical findings other than those present on his previous admission were detected.

Laboratory studies revealed hemoglobin 2.4 grams, WBC 19,350, polymorphonuclears 98%, lymphocytes 2%, RBC 1,900,000. Total protein 4.7 with albumin 2.0. Icteric index 3.0. Urinalysis—specific gravity 1.018, protein 3+, sugar negative, sediment, RBC 0 to 1, WBC 15 to 20, and Bence-Jones protein negative.

X-ray examination—Chest x-ray now revealed a very large mediastinal tumor mass which extended in all directions from the upper mediastinum and was somewhat lobulated in outline. The lung fields appeared clear and a metastatic bone survey was negative.

Blood culture was sterile. The *electrocardiogram* showed an irregular rhythm due to auricular flutter with some variation in the A.V. response.

Clinical courses—During his stay the patient ran a daily temperature up to 101°. He received blood transfusions. On the eighth hospital day he developed a right flaccid hemiplegia and periodic seizures of twitching of the right side of the face. He became aphasic, his temperature rose to 102°, and he expired on the ninth hospital day.

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John C. Leonard, M.D. Director of Medical Education, Hartford Hospital; Associate Clinical Professor of Medicine, Yale Medical School.

I shall divide my subjects for Differential Diagnosis into three sections:

I Infection
II Collagen Disorders
III Malignancy

I *Infections.* I shall discuss only those infections which may be atypical or difficult of diagnosis. Among these are: a) Osteomyelitis, b) Esophageal perforation (e.g. Foreign body with resultant mediastinitis), c) Perinephric abscess, d) Subphrenic abscess, e) Appendicitis with pylephlebitis, f) Cholangitis with liver abscess or abscesses, g) Amebic abscess of liver, h) Subacute bacterial endocarditis with organism difficult to culture and i) Tuberculosis.

I believe that we should rule these out because long term antibiotic therapy was ineffectual.

II *Collagen Disorders.* a) Periarteritis (Polyarteritis) Nodosa and b) Dermatomyositis.

We shall rule out the collagen disorders because cortisone was not effective, not even in a temporarily palliative manner.

III *Malignancy.* I believe that this man died of a malignant tumor with metastases and I shall list some of those which this might be: a) Malignant melanoma, b) Teratoma (testis), c) Kaposi's sarcoma, d) Carcinoma of the male breast, e) Ca of Esophagus, f) Ca of Stomach, g) Ca of Gall bladder, h) Ca of liver (Hepatoma), i) Ca of pancreas and j) Ca of kidney, k) Ca of thyroid, l) Malignant Lymphoma (Hodgkin's or Lymphosarcoma), m) Myeloma, n) Lung and o) Thymus (Malignant Thymoma).

Since the diagnosis of Acanthosis Nigricans seems to have been well established we have further support for the evidence that this patient died of a malignancy. Such a malignancy may be either above or below the diaphragm but I feel, in this case, that the primary malignancy is above the diaphragm. While the primary malignancy is more likely to be one of the less rare variety, I should like to take a "flyer" and call this a Malignant Thymoma with severe, refractory anemia.

Thomas A. Warthin, M.D. Chief of Medical Service, West Roxbury Veterans Hospital; Associate Clinical Professor of Medicine, Harvard Medical School.

This fifty-nine-year-old, white, married, schoolbus driver succumbed to an illness of thirteen months' duration, characterized by nonspecific constitutional symptoms, associated with continued fever and striking weight loss. Of outstanding

importance in the physical examination were the presence of hypertrophic hyperpigmented papillae in the axillae, groins and public region consistent with the diagnosis of acanthosis nigricans. This latter skin disorder[1] is one of three skin abnormalities which have been found to have a highly significant association with an underlying carcinomatous lesion. Dermato-myositis and dermatitis herpetiformis have also been found to have a close, but not as striking, association with malignant disease. Acanthosis nigricans may appear prior to puberty and in these instances does not carry the "malignant" relationship that one associates with the adult type. A pseudo-acanthosis must also be distinguished from this and is found only in obese, darkly pigmented individuals; whereas, the adult (malignant) type is found in individuals of all degrees of pigmentation and physical nutrition. An interesting factor in this relationship is that it is essentially 100% consistent in its occurrence. The skin lesion may precede by some year or years the occult development of the carcinoma and will fluctuate in intensity during periods of treatment directed toward the tumor. The carcinoma is invariably an adenocarcinoma and characteristically has its origin in the abdominal organs rather than from the lung or breast, although the latter association has been noted. With this background and with the typical clinical description in this patient one's search for the fatal tumor has already become somewhat limited.

We are given two additional leads to assist us in our diagnosis. The first, is the appearance of electrocardiographic changes during the final hospitalization which are in keeping with the type associated with tumors involving the heart and pericardium. The commonest tumors metastasizing to the heart are bronchogenic carcinoma; malignant melanoma; various sarcomas, including lymphosarcoma and Hodgkin's Disease; and carcinomas of the esophagus, parotid, colon, adrenal, penis, pancreas, testicle, and kidney. Gastric carcinoma, for some reason, does this extremely rarely. In the series of autopsied cases reported by Gassman, Meadows, and Baker,[2] in the September, 1955, AMERICAN JOURNAL OF MEDICINE, metastatic carcinoma of primary unknown origin also is high on the list. We certainly can apply that to this patient.

The other point is the presence of a very large mediastinal tumor mass, lobulated in outline in the upper mediastinum noted in the terminal chest X ray. This type of tumor mass is often seen in carcinoma of the stomach or pancreas which has metastasized through the lymphatics to this mediastinal area.

The anemia noted during his first admission suggests blood loss basis such as may be found in carcinomas of stomach or right colon. Fever and leukocytosis are not uncommon in the latter, and

continued on next page

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positive tests for blood in the stool noted. The terminal blood findings could be found with these tumors or others which now involve extensive areas of marrow.

It would not be too difficult to miss a carcinoma of the pancreas or adrenal at the time of the exploratory laparotomy; whereas, a lesion of the stomach would have been hard to overlook. His age group, the striking weight loss, the cerebral metastases, and constipation are all found with considerable frequency in pancreatic neoplasm. A primary lung carcinoma, suggested by his cough and smoking, should have an occult pulmonary lesion in the final chest X ray, as should metastasis from a kidney tumor. It would be unusual not to see clubbing of the fingers. A male breast cancer would not be missed on physical examination.

For these reasons, I believe that the primary carcinoma arose in the pancreas rather than in one of the other adjacent chest or abdominal organs.

Campbell A. McNicol, M.D. Assistant Pathologist, Rhode Island Hospital.

At autopsy the most striking feature on external examination of the body was a marked degree of emaciation. There was noted a patchy, brown discoloration of the periumbilical skin. No other areas of pigmentation of the skin of the body were noted. Examination of the thoracic cavity revealed a large hilar mass, which measured 10 x 8 x 9 cm., and was quite discrete from adjacent lung parenchyma on either side. This mass with trachea and bronchi attached weighed 670 grams. On section, it consisted of numerous confluent tumor nodules, some of which were necrotic and hemorrhagic. Examination of the lungs revealed thickening and induration of the right main stem bronchus and on cross section the bronchial wall appeared to be grossly involved by tumor. There was one small nodule of metastatic tumor in the liver and both adrenal glands were practically completely replaced by tumor. Examination of the brain revealed metastatic tumor nodules in the right frontal and left occipital lobe.

Histologic sections of the right main stem bronchus revealed a primary undifferentiated bronchiogenic carcinoma with invasion of the wall of the bronchus. The tumor in its metastases retained its undifferentiated structure.

The presence of the dermatologic condition of acanthosis nigricans is of interest in this case. This skin lesion is, in its so-called "malignant" form, almost invariably associated with internal cancer. While such carcinomas are usually of the adenocarcinoma variety, there have been cases reported of the finding of acanthosis nigricans in association with other types of tumor, including epidermoid carcinoma. The spiking temperature and reversal

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of the albumin-globulin ratio, noted clinically, are not easily explained. It is known, however, that in the presence of widespread tumor such clinical manifestations are not infrequent and must not necessarily be related to any specific type of tumor.

This case illustrates once again the cryptogenic nature of many internal cancers, a notable example of which is carcinoma of the lung.

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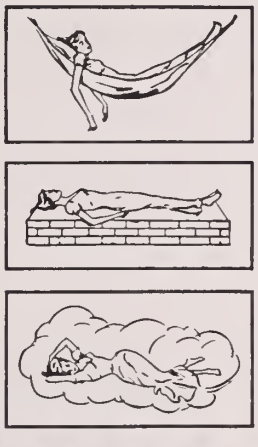
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STORY OF THE RHODE ISLAND HOSPITAL HEART STATION

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Naturally the war interrupted a good deal of the hospital routine and subsequent to that for a considerable period no technician could be found who could operate the machine and develop the records satisfactorily, nor was there anyone who knew enough to be of any help in interpreting them. Electrocardiography had not yet been popularized and there were three good reasons for this: one was that a satisfactory portable instrument was slow in coming into use; secondly, the interpretation of the records required long training; and third, Rhode Island Hospital was not a teaching institution.

The original instrument remained in the hospital for five years. At the end of that time I had changed my office to 124 Waterman Street and had plenty of room to install an electrocardiograph, and needed one there. However, I did not like to take it away, for though at that time the staff still took very little interest in it, I felt that there should be one in the hospital. I had two fine elderly lady patients on Hope Street—Miss Esther Hinckley Baker, and her companion, Miss Elizabeth Dorrance Bugbee. When the latter died I asked Miss Baker if she would like to give an instrument to the hospital as a memorial. This she quite gladly agreed to do. That instrument, Miss Baker's gift, served for a number of years until the smaller and portable types were built.

The radical change in the attitude toward electrocardiography coincided with the manufacture of a strictly portable instrument. According to my records, I obtained one of these for the first time for my office in August 1927. It was in two parts, one containing the battery, from which it was operated, and the other the galvanometer. That made it possible to go to the home of a patient and get a record. In June eight years later, or 1935, I obtained an all-electric portable instrument, still in two parts, which could be operated from house current. This was made by the Cambridge Instrument Co. of New York and I think they were the first to manufacture a portable electrocardiograph to be operated from the 60-cycle house current, thereby eliminating the need for batteries. It was not particularly easy to handle as each of these cases weighed about 40 lbs. Not very long after that the so-called Simpli-Trol was manufactured by the same concern, all of the parts being assembled in one small case, weighing only about 30 lbs., and finally came another modification—the Simpli-Scribe, which is a direct-writer, producing a finished record which can be read as soon as it is taken, without having to wait for the developing process. In the meantime, other concerns were manufacturing various types of these instruments.

After Harry Clough left it was difficult to find any medical man who was willing to take over the technical work. I had several technicians, none of whom could get the knack of taking good records with the early complicated apparatus, but in 1924 Mrs. May E. Colwell took the job and no one has deserved greater credit for the success of the routine operation of the department than she. When she began some of the technical difficulties were almost heart-breaking and certainly most discouraging but her determination, intelligence and resourcefulness prevailed and kept the place efficient from the time she became connected with it. The work has never been light. She has had the details of carrying the place on under her direction continuously. It has sometimes been difficult to keep a full staff of helpers because of illness and matrimony but seldom has anyone resigned except for those reasons.

The lack of suitable quarters in which to carry on was a handicap for a long time. As before mentioned, the instrument was first set up in the X-ray room in the basement, but later was moved to a small room on the first floor across from the drug room. This, however, was entirely inadequate. Finally Dr. Peters retired as superintendent in 1934 and his apartment in the main building was

continued on page 710

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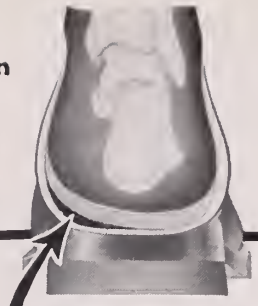
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STORY OF THE RHODE ISLAND HOSPITAL HEART STATION

continued from page 708

vacated and made available for electrocardiography and other heart studies. These excellent quarters, henceforth known as the "Heart Station" were remodeled to suit that purpose. One large room was cut up so that it was quite satisfactory for the technical work and fluoroscopy and another was used for a conference room.

Mrs. Daniel Beckwith and her family had long been patients of mine and were much interested in the hospital. She heard about some of our financial difficulties and offered to make some contribution if it would help. She first of all volunteered $1000. and from time to time later contributed several thousand more, out of which new equipment was acquired which was much needed and which could be satisfactorily used in our new quarters, and it was these available funds which prompted the request to have a resident in the Heart Station.

When I retired from active duty on the medical staff, it was voted in the staff meeting that I be asked to continue carrying on the electrocardiographic work. Soon after, I suggested to the staff that there be a paid resident, whose duties would be entirely devoted to that department, and I wrote the following letter:

Feb. 22, 1934

My dear Westcott:

As I have already told you, I have in mind a plan for increasing the usefulness of the Cardiac Department.

The quarters for the electrocardiographic work, as you know, are quite inadequate for the work we have lately had to do. The hospital, I understand, is willing to provide a more suitable place. If it should meet with the approval of the Executive Committee I should like to suggest that when suitable quarters are available, there be installed a fluoroscope with orthodiagraph attachment, and that there be appointed a resident whose time would be devoted to cardiac work. The purpose would be twofold: first, to make the department of more value to the medical service and the hospital in general, and secondly to give the holder of the appointment an opportunity to carry on a more intensive study of heart disease.

There is at the moment cash enough available to supply the equipment and pay such a resident a small salary for perhaps three or four years. It is quite possible that a permanent fund might be obtained for this purpose.

My ideas in general as to the work of a resident would be as follows: first of all he should give especial attention to the fluoroscopy and orthodiagraph work, and plan that work so that members of the Out Patient and Hospital staff who wished to do so could be present when the routine fluoroscopy was being done; that he should be available for emergency electrocardiographic work; that he should help in the Out Patient Clinic; that he should have opportunity to study the house patients, and carry on any research work on these patients which would meet the approval of the staff.

You have already told me of your approval of the suggestion, and I would be glad if you would bring the matter before the Executive Committee.

Very sincerely yours,

(Signed) FRANK T. FULTON, M.D.

P.S. It might develop that it would be wise to allow such a resident the privilege of spending one day a week in some Boston clinic.

F. T. F.

This was approved quite promptly and Dr. Frank B. Cutts, who had just finished his internship at the Massachusetts General in Boston and was planning to come to Providence to practice, was offered and accepted the position for a year.

The expansion of our facilities quite promptly led to a weekly conference where the staff could meet and discuss some of the cardiac problems and cardiac cases. This became popular at once but was interfered with during World War II as the staff was much depleted. After the men returned, however, these conferences were resumed and well attended, more particularly by the residents and the younger men. Now that the interns and residents are so many, the facilities of the present meeting place are fairly well taxed.

The Heart Station was never intended to be strictly a heart clinic. It was originated for doing the technical electrocardiographic work, and not for the clinical care of patients. Those admitted to the hospital service still remained on the hospital medical services and those from the Out Patient were sent back to the Out Patient Clinic for advice. The department would have lost much of its value had it been made a special clinic and taken away from the medical service. It was especially stressed when the resident came, that the members of the Heart Station should not

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initiate any of the treatment of cardiac patients but should supply to the medical staff any information that was recognized as being useful and a helpful guide. It was understood, however, that the resident should have opportunity at all times for observation and study of the cardiac patients on the wards.

The work of the department has grown tremendously. When we left our cramped quarters on the main floor of the hospital, the monthly average of records called for was 115, or a total for the year 1933 of 1382. In 1954 the average per month was 422, with a total for the year of 5071, keeping three full-time and two part-time girls busy taking care of the technical work. Now, an electrocardiogram is one of the first things the hospital staff asks for and insists upon. The records are interpreted by some member of the staff who has been working there long enough so that his opinion has a value. It has been for years the established routine to deliver a written opinion to the ward where the patient is located, on the following day after a record is taken. The only thing that interferes with this practice is insufficient technical help. If it is an emergency, a verbal opinion may be had at once. So much has been written in connection with electrocardiographic work that it is rather difficult for one person to keep informed about it all. There is one danger for the younger men, the students, interns and residents; that is that they may tend to emphasize too much the electrocardiographic findings. There is much else beside that which can be found out in connection with the diagnosis and treatment of heart disease. The correlation with the autopsy findings, which has been a part of the Heart Station studies for a number of years, is very valuable.

During the early years, as has been previously said, there wasn't a great deal of interest among the medical men so far as taking an active part in the work was concerned. Dr. Cecil C. Dustin and Dr. Henry L. C. Weyler were about the first to become interested and they were eventually very helpful in interpreting the records.

Since getting the Heart Station established, we have always had a resident, a young physician who has completed his internship. This residency soon was in demand and gradually there was an increasing number of applicants every year from all parts of the country and also abroad, as far away as South America, Iraq and India. Naturally the number fell off somewhat during the war but one year just after the war there were twenty-two inquiries regarding it. It has been very gratifying that we have had so many well qualified men make application for this position in spite of the fact that it is not associated with a teaching institution.

continued on next page

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It has seemed worthwhile to keep in touch with the men who have served as cardiac residents, as to where they are, what positions or privileges they may have, and how many of them are making heart disease a major study. Already many of these details are recorded and it has been suggested that as a matter of interest this information be kept in the Heart Station and revised periodically. The data collected up to the present gives one the impression that their experience in the Heart Station has helped them to make good contacts where they have ultimately located.

Dr. Cutts has remained continuously on the staff of the Cardiac Department since his residency and on his return from service in World War II was appointed director.

There are now hanging in the Heart Station, signed and framed, photographs of the following distinguished men in the field of cardiology: Sir Thomas Lewis, Henry A. Christian, Alfred E. Cohn, Lewis A. Conner, Elliott C. Cutler, George Dock, James B. Herrick, Samuel A. Levine, Paul D. White, and Frank N. Wilson.

It would be appropriate to say something about the men who had the most to do with the early development of the use of the electrocardiograph. In my own mind there is little question but that Sir Thomas Lewis was the outstanding man in Europe in this regard. His book, "The Mechanism of the Heart Beat," which appeared in 1911 and to which I referred in the beginning, was the result of a very elaborate study with the use of that instrument. However, credit must be given to Sir James Mackenzie for his part in these early studies. Much of his work was done in connection with a country practice. So far as I know, the polygraph was the product of his own ingenuity and his use of it added greatly to the understanding of heart irregularities. But the electrocardiograph showed all that the polygraph did, and showed it much better, besides giving ultimately, far more information.

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Sir Thomas disliked very much being involved in consultation work. His conferences he liked to have with the attending physician and the patient. The discussions and conferences with the family and friends which were apt to follow, he could not well tolerate. He was very jealous of his time which he preferred to use in finding out methods and establishing results. He could stop long enough in his teaching to give a lecture, which was always extraordinarily informative, but he was chiefly interested in exploring the unknown: in other words, he was really a research man. I was rather surprised at the time, that there were so few young men under his tutelage during the first summer I was with him. There were but six of us—two were from Johns Hopkins, a third, a particular friend of mine from Syracuse. I don't recall what connections the others had. Of course this was only about a year after the first edition of his book was published and the subject had not been much publicized. He had a brilliant mind, was very thorough, went to the bottom of his subject, was an extraordinarily clear thinker and, as noted previously, had great facility of expression, which is not always true of an investigator.

Three of the outstanding men in this country who contributed greatly to the early knowledge of cardiovascular diseases have been Dr. Frank N. Wilson, Dr. Samuel A. Levine and Dr. Paul D. White. Dr. Wilson and Dr. Levine were about the same age and about three years younger than Dr. White. They all three began to give that subject their special attention at about the same time, Dr. Levine at the Brigham, Dr. White at the Massachusetts General and Dr. Wilson at the University of Michigan, each of these being first-class institutions and located in about the best possible kind of environment. These men have all attained national and international distinction and they have all been among my best friends. Dr. White has written a great deal and in 1931 published what I believe to be the first comprehensive book on heart disease in this country since electrocardiography became well established. I became acquainted with Dr. Levine during my frequent visits to the Peter Bent Brigham Hospital, which came about because of my early acquaintance and friendship with Dr. Christian. Dr. Levine had the electrocardiograph at the Brigham Hopital in operation before ours arrived at the Rhode Island and he was of distinct help in getting us over some difficulties. Recently he has been paid a wonderful tribute. Mr. Charles E. Merrill of New York City gave $500,000 to the Harvard Medical School, as a permanent endowment for the "Samuel A. Levine Professorship of Medicine" to carry on research in cardiovascular disease.

Dr. Wilson, I think without doubt, did more

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STORY OF THE RHODE ISLAND HOSPITAL HEART STATION

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scientific research in connection with the electrocardiograph than either of the others or than anyone else in this country during the period of his activity. Most of his work was done at Ann Arbor, Michigan, altho he was for four years, from 1916 to 1920 at Washington University in St. Louis. After that he returned to the University of Michigan. He was most prominent on account of his research, much of that being conducted by experiments on dogs. As a result of this he was largely responsible for increasing the number of leads which are used in taking an electrocardiogram. For some time only the three conventional leads were used; now, usually at least twelve are taken. In this connection Dr. Levine contributes the following comment: "It is of interest that Wilson started his intensive study of the ventricular complex (Q-R-S-T waves) at the time that Lewis really gave up his interest in electrocardiography. In the early nineteen twenties Lewis turned his attention to the peripheral circulation, the capillaries, and to the mechanism of pain, thinking there was little more to be learned from the galvanometer. Despite this Wilson succeeded in clarifying the significance of the ventricular complex and laid the foundation of our present knowledge of the electrocardiographic diagnosis of myocardial infarction, ventricular hypertrophy and bundle branch block." I have always regretted that I didn't go to Ann Arbor to visit and study with Dr. Wilson for a while. Unfortunately, he died at the age of 62, too early to have gotten the greatest satisfaction out of his work. One might add the same thing about Sir Thomas Lewis, who died when he was 64, while still in his prime.



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April 24-26. Connecticut State Medical Society, at Hamden, Conn. (High School)

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Sept. 27-29. New Hampshire-Vermont Societies, at Portsmouth, N. H. (Wentworth-by-the-Sea)

Oct. 30-Nov. 1. New England Postgraduate Assembly, at Boston (Statler Hotel)

NATIONAL

Feb. 13-16. American College of Surgeons (Sect. Meeting), at Philadelphia, Pa. (Bellevue-Stratford)

Mar. 19-22. American Academy of General Practice, at Washington, D. C. (Armory)

April 16-20. American College of Physicians, at Los Angeles, Calif. (Shrine Auditorium)

April 16-18. American Academy of Pediatrics (Spring Meeting), at Houston, Texas (Auditorium)

April 23-26. Industrial Medical Association, at Philadelphia, Pa. (Convention Hall)

April 30-May 4. American Psychiatric Association, at Chicago, Ill. (Morrison Hotel)

May 6-8. American Society of Clinical Investigation, at Atlantic City, N. J. (Steel Pier)

May 28-31. American Urological Association, at Boston, Mass. (Statler Hotel)

June 9-11. AMERICAN MEDICAL ASSOCIATION, at Chicago, Ill. (Navy Pier)

Sept. 2-8. International Society of Hematology, at Boston, Mass. (Statler Hotel)

Sept. 9-12. International College of Surgeons, at Chicago, Ill. (Palmer House)

Oct. 7-13. American College of Surgeons (Clinical Cong.), at San Francisco, Calif. (Civic Auditorium)

Oct. 8-11. American Academy of Pediatrics, at New York, N. Y. (Statler Hotel)

Oct. 8-12. American Society of Anesthesiologists, at Kansas City, Mo. (Auditorium)

Oct. 27-31. American Heart Association, at Cincinnati, Ohio. (Netherland-Plaza Hotel)

Nov. 12-16. American Public Health Association, at Atlantic City, N. J. (Auditorium)

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Five new titles have been added to the Davenport Collection and are available for circulation:

Enzo Girone—Io E I Pazzi. Casa Editrice Ceschina, Milano, 1953. Gift of Dr. Ronchese.

400 Years of a Doctor's Life. Collected and Arranged by George Rosen and Beate Caspari-Rosen. Schuman, N.Y., 1947. Gift of Dr. Ronchese.

Ugo Piazza—Oggi non visito . . . Edizioni Minerva Medica, Torino, 1955. Gift of Dr. Ronchese.

Piero Orlandini—Il Medico Nomade. Garzanti, Italy, 1950. Gift of Dr. Ronchese.

Henry W. Wells—Poet and Psychiatrist. A Critical Portrait of Merrill Moore, M.D. Twayne Publishers, N.Y., 1955.

Recent Day Fund purchases are:

Paul B. Beeson & others, editors—The Year Book of Medicine. 1955-1956 Series. The Year Book Publishers, Inc., Chic., 1955.

Collected Papers of the Mayo Clinic and Mayo Foundation. Vol. XLVI, 1954. W. B. Saunders Company, Phil., 1955.

William Dock & I. Snapper, editors—Advances in Internal Medicine. Vol. VII. The Year Book Publishers, Inc., Chic., 1955.

Gilbert S. Gordan, editor—The Year Book of Endocrinology. 1954-1955 Series. The Year Book Publishers, Inc., Chic., 1955.

Lewis M. Hurxthal. In Cooperation with A. Seymour Parker & Hirsh Sulkowitch—Practical Endocrinology. Landsberger Medical Books, Inc., McGraw-Hill, N.Y., 1955.

S. S. Lichtman—Diseases of the Liver, Gallbladder and Bile Ducts. 2 vols. 3rd ed. Lea & Febiger, Phil., 1953.

Grace E. Barstow Murphy—Your Deafness is not You. Harper & Brothers, N.Y., 1954.

John F. Oliven—Sexual Hygiene and Pathology. A Manual for the Physician. J. B. Lippincott Co., Phil., 1955.

Edith L. Potter—Pathology of the Fetus and the Newborn. The Year Book Publishers, Inc., Chic., 1953.

E. A. Spiegel, editor—Progress in Neurology and Psychiatry. An Annual Review. Vol. X. Grune & Stratton, N.Y., 1955.

John E. Sutton—Minor Surgery. Landsberger Medical Books, Inc., McGraw-Hill, N.Y., 1955.

Paul Titus—The Management of Obstetric Difficulties. Revised by J. Robert Willson. 5th ed. The C. V. Mosby Company, St.L., 1955.

Franklin H. Top & others—Communicable Diseases. 3rd ed. The C. V. Mosby Company, St.L., 1955.

William B. Wartman, editor—The Year Book of Pathology and Clinical Pathology. The Year Book Publishers, Inc., Chic., 1955.

William Firth Wells—Airborne Contagion and Air Hygiene. An Ecological Study of Droplet Infections. Harvard University Press, Cambridge, 1955.

Review volumes from the Rhode Island Medical Journal were:

Ciba Collection of Medical Illustrations. Vol. 2. A Compilation of Paintings on the Normal and Pathologic Anatomy of the Reproductive System Prepared by Frank H. Netter, M.D. Edited by Ernst Oppenheimer, M.D. Ciba Pharmaceutical Products, Inc., Summit, N.J., 1955.

Otto Deutschberger—Fluoroscopy in Diagnostic Roentgenology. W. B. Saunders Company, Phil., 1955.

John F. Fulton & others, editors—A Textbook of Physiology. 17th ed. W. B. Saunders Company, Phil., 1955.

Benjamin Harrow—Casimir Funk. Pioneer in Vitamins and Hormones. Dodd, Mead & Company, N.Y., 1955.

A. McGehee Harvey & James Bordley III—Differential Diagnosis. The Interpretation of Clinical Evidence. W. B. Saunders Company, Phil., 1955.

Conrad R. Lam, editor—Cardiovascular Surgery. Studies in Physiology, Diagnosis and Techniques. Proceedings of the Symposium held at Henry Ford Hospital, Detroit, Michigan, March, 1955. W. B. Saunders Company, Phil., 1955.

Herbert Lawrence—The Care of Your Skin. Little, Brown and Company, Bost., 1955.

Alton Ochsner & Michael E. DeBakey, editors—Christopher's Minor Surgery. 7th ed. W. B. Saunders Company, Phil., 1955.

Sheldon C. Reed—Counseling in Medical Genetics. W. B. Saunders Company, Phil., 1955.

A. A. Roback—Present-day Psychology. An Original Survey of Departments, Branches, Methods, and Phases, including Clinical and Dynamic

Psychology. Philosophical Library, N.Y., 1955.

Richard T. Shackelford—Bickham-Callander Surgery of the Alimentary Tract. 3 vols. W. B. Saunders Company, Phil., 1955.

Henry K. Silver, C. Henry Kempe & Henry B. Bruyn—Handbook of Pediatrics. Lange Medical Publications, Los Altos, Calif., 1955.

Robert H. Williams, editor—Textbook of Endocrinology. 2nd ed. W. B. Saunders Company, Phil., 1955.

Edward T. Yorke—Salt and the Heart. Drapkin Books, Linden, N.J., 1953.

Fellows of the Society have given the following items to the Library:

From *Dr. P. Batchelder*—10 volumes of The X-ray Technician.

From *Dr. P. P. Chase*—Ciba Foundation Colloquia on Endocrinology. Vol. VIII. The Human Adrenal Cortex. Little, Brown and Company, Bost., 1955.

From *Dr. G. W. Davis*—151 journals.

From *Dr. R. Hammond*—medical journals.

From *Dr. H. A. Lawson*—Thesaurus Sanitatis . . . by Johann Jacob Bräuner. Franckfurt, 1713. 2nd ed.

From *Dr. H. G. Partridge*—Medical Practice in Curing Fevers: . . . by Theophilus Lobb. Lond. 1735. This volume was owned by Amos Throop, the first President of the Rhode Island Medical Society, and has his signature.

Transactions of the New England Obstetrical and Gynecological Society. Vol. VIII. 1954.

From *Dr. C. Potter*—medical journals.

From *Dr. F. Ronchese*—Two Histories of Medicine of the XVth Century (On Medicine and Physicians by Giovanni Tortelli and On the Antiquity of Medicine by Gian Giacomo Bartolotti) Edited and Translated by Dorothy M. Schullian and Luigi Belloni. Milano, 1954.

Massachusetts General Hospital Memorial and Historical Volume. Together with the Proceedings of the Centennial of the Opening of the Hospital. Bost., 1921.

Historical Sketch of the Rhode Island Hospital Training School for Nurses, 1882-1932. Prov., (1932).

More of My Life by Andrea Majocchi. Translated by Wallace Brockway. Knight Publishers, N.Y., 1938.

Il Sangue e Gli Organi Emolinfopoietici Nell'Infezione Sifilitica by Gian Battista Cottini. Editoria Liviana, 1947.

Il Problema del Cancro Visto dal Medico Practico. Fratelli Lega, Faenza, 1955.

Other gifts were:

From *Martha B. Bates, M.D.*—74 volumes.

From *Prof. Robert T. Beyer*—medical journals.

From *Donald C. Gates, M.D.*—medical journals.

Gift of the Author: Martin Ekblad — Induced Abortion on Psychiatric Grounds. A Follow-up Study of 479 Women. Copenhagen, 1955.

Gift of the Health Library, State Department of Health: medical journals.

Gift of Peters House Library, Rhode Island Hospital: medical journals.

Gift of the American Medical Association: Louis H. Bauer—Private Enterprise or Government in Medicine. Springfield, Ill., 1948.

New and Nonofficial Remedies Accepted by the Council on Pharmacy and Chemistry. J. B. Lippincott Company, Phil., 1955.

A Planning Guide for Establishing Medical Practice Units. Published through a Grant made by Sears-Roebuck Foundation. Chic., 1955.

Tenth National Conference on Rural Health. Milwaukee, 1955.

Gift of the American Medical Education Foundation: Annual Report 1954. Chic., 1955.

Gift of the American Society of Anesthesiologists, Inc.: Anesthesiology Handbook. Chic., 1955.

Gift of the American Urological Association: Transactions of the Western Section, vol. 22. 1955.

Gift of the Association of American Physicians: Transactions, Sixty-eighth session, vol. LXVIII, Phil., 1955.

Gift of the Association of American Soap and Glycerine Producers, Inc.: Louis Schwartz—The Prevention of Occupational Skin Diseases, N.Y., 1955.

Gift of the British Government: Report of the Medical Research Council for the Year 1953-1954. Lond., 1955.

Gift of the Committee on Conservation of Hearing, American Academy of Ophthalmology and Otolaryngology: Quarterly report no. 6, April 1-June 30, 1955.

Gift of the Connecticut State Department of Health: 105th Registration Report, 1952. Hartford, 1954.

Gift of the Harvard School of Public Health: Annual Report of the Dean, 1954. Cambridge, 1955.

Gift of the Institute of Life Insurance: Life Insurance Fact Book, N.Y., 1955.

Gift of the Life Insurance Association of America: Proceedings of the Forty-eighth Annual Meeting. N.Y., 1954.

Gift of the M&R Laboratories: Reports of the M&R Pediatric Research Conferences. 13th — Adrenal Function in Infants and Children. 15th — Respiratory Problems in the Premature Infant. 1955.

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BOOK REVIEWS

DIFFERENTIAL DIAGNOSIS. The Interpretation of Clinical Evidence by A. McGehee Harvey, M.D. and James Bordley III, M.D. W. B. Saunders Co., Phil., 1955. $11.00

This is a unique publication, being the first one in this reviewer's experience, which has presented the problem of differential diagnosis in the form essentially of clinical pathological conferences. This type of presentation has certainly become familiar to most everyone through the medium of the Massachusetts General Hospital case records as published in the NEW ENGLAND JOURNAL OF MEDICINE, and we all agree that this is an excellent way to offer basic differential diagnosis. This method has its limitations in that certainly many problems do not necessarily result in death or surgery, so that absolute pathological confirmation is not always available, and this would seem to limit this publication in its usefulness. There are several other, perhaps minor criticisms that may be offered. The whole first chapter is devoted to aortic insufficiency and although other valvular cardiac defects are discussed, one wonders why this single condition is isolated for such extensive discussion. Most of the usual, and some of the unusual, medical disorders are covered in the book but it seems strange to this reviewer that diseases of the blood as such are not covered and very little attention is given to disorders of the central nervous system. Only meningitis, as an infectious disease is presented, although in the discussion other diseases are covered.

Generally speaking, the material is presented well and the discussions following each case outline are excellent. Pathological findings are well correlated and it is very evident that a lot of very painstaking work has gone into the preparation of this volume. An outstanding aspect of the volume is a section devoted to unknown cases for study in which the reader is given an opportunity to arrive at his own diagnosis and then by referring to a subsequent section can compare his reasonings with those of the authors. There is also a section on laboratory values of clinical importance and in another section there is a special index of symptoms, signs, and laboratory findings. This in itself makes the book very valuable, providing an alphabetical reference to specific symptoms and syndromes.

This book should be a welcome addition to the library of those interested in internal medicine and its many and varied problems of diagnosis, but this reviewer does not feel that this volume can be relied upon for a complete study in differential diagnosis.

JOSEPH G. MCWILLIAMS, M.D.

TEXTBOOK OF ENDOCRINOLOGY. Edited by Robert H. Williams, M.D. W. B. Saunders Co., Phil., 1955. $13.00

This second edition of Doctor Williams' textbook is a basic work on endocrinology. It contains all the valuable, timely data necessary to the study of any problem relating to the endocrine glands, and manages withal to be concise and clear in the treatment of a vast, complicated field of medicine.

In the first chapter which deals with general principles of the physiology of the endocrines, it delineates the phylogenetic aspects of the endocrines, their interrelationships with one another and with the nervous system, the general chemical nature of hormones, their manufacture, storage transportation, activation and inactivation, their mechanism of action and their excretion.

Thereafter, from the pituitary on, a chapter is devoted to each gland, its anatomy, physiology, chemistry and the diseases inherent to each one. Thus, a chapter follows on the thyroid, the adrenals, the testes, the ovaries, the pancreas, the parathyroids. Five other chapters follow dealing with: the influence of the endocrine glands upon growth and development, neuroendocrinology, obesity, laboratory diagnostic and assay procedures, and diagnoses and treatment of endocrinopathies with hormone preparations.

Other well-known contributors besides Doctor Williams represent authorities in their subject from various medical centers across the country. They are: Doctors William Daughaday, St. Louis; Peter Forsham, San Francisco; Harry B. Friedgood, Toledo; John Eager Howard, Baltimore; Edward C. Reifenstein, New York; William Wallace Scott, Baltimore; George V. Smith, Brookline; George W. Thorn, Boston; Lawson Wilkins, Baltimore.

The book is splendidly illustrated with photographs, photomicrographs, lucid graphic charts and contains appended to each chapter a complete bibliography.

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BOOK REVIEWS

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As Doctor Williams points out in his preface, "There are few major diseases that do not influence endocrine function, and vice versa. Therefore, knowledge of endocrinology is important in every branch of medicine." It must then follow as the night, the day, that this book is of outstanding value to all physicians. Advances in endocrinology have kaleidoscoped so rapidly in recent years, that it is good, indeed comforting to have at hand as complete a source of information on the subject as Doctor Williams' textbook.

JEANNETTE E. VIDAL, M.D.

OFFICE PROCEDURES by Paul Williamson, M.D. W. B. Saunders Company. Phil., 1955. $12.50

This is a very well organized and well illustrated book, written in a chatty, conversational manner. It is not too large and is bound in such a way that when open it lies flat on the table for easy use.

It is meant for the general practitioner and I mean *general*. It consists of fifteen sections: Ear, Nose and Throat; Eye; Musculoskeletal System; Gynecology; Obstetrics; Urology; Proctology; Pediatrics; Minor Surgery; Internal Medicine; Psychological Testing; Anesthesia; Physiotherapy; The Small Laboratory; and Roentgenography.

The practitioner who will attempt all the procedures listed should be chock-full of self confidence, have a strong leaning towards surgery and live in an area where there is not such a plethora of specialists as exists in the state of Rhode Island. He should also have a large, well-equipped office with office help such as an X-ray and laboratory technician and a nurse able to do physiotherapy.

The book would be of great help to a country practitioner as there are clearly described and illustrated "tricks of the trade" which are not taught in medical school or in most internships and only learned from others by word of mouth or discovered by chance or natural born ingenuity.

It tells you how to do things to and with the patient with least discomfort and best results, such as inserting a vaginal speculum or "treating the obstetrical patient as if she were queen for a day instead of an outsider who happened to butt in on an obstetrical procedure." Minor surgery *plus* is well covered.

I heartily recommend this book to all general practitioners and, if I may be so rash, would say that some specialists might also pick up a few points by reading the sections devoted to their particular departments.

AMY E. RUSSELL, M.D.

ON THE MEDICAL LIBRARY BOOKSHELVES

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Gift of the Metropolitan Life Insurance Company: pamphlets.

Gift of the Muscular Dystrophy Associations of America, Inc.: Proceedings of the third Medical Conference, N.Y., 1954.

Gift of the National Association of Medical-Dental Bureaus: Proceedings of the Sixteenth Annual Convention, Kansas City, Mo., 1954.

Gift of the Pan American Sanitary Bureau: Annual Report of the Director, 1954. Wash., 1955.

Gift of the Rockefeller Foundation: The President's Review from the Rockefeller Foundation Annual Report 1954. N.Y., 1955.

Gift of the Rockefeller Institute for Medical Research: Studies, vol. 150. N.Y., 1955.

Gift of the U.S. Government: Cardiovascular Disease. Data on Mortality, Prevalence, Control Activities. Wash., 1955.

W. F. von Oettingen—The Halogenated, Aliphatic, Olefinic, Cyclic, Aromatic, and Aliphatic-aromatic Hydrocarbons including the Halogenated Insecticides, Their Toxicity and Potential Dangers. National Institute of Health. Wash., 1955.

Public Health Service Technical Report on Salk Poliomyelitis Vaccine, June 1955. U. S. Dept. Health, Education, and Welfare. Wash., 1955.

Transactions of the 14th Conference on the Chemotherapy of Tuberculosis held on Feb. 7-10, 1955, at Fulton County Medical Society, Atlanta, Ga. Veterans Administration, Army and Navy. Wash., 1955.

Veterans Administration. Technical Bulletins Series 10. Vol. VII, 1954. Wash., 1955.

Through our special exchange arrangement with the Universitetsbiblioteket, Lund, Sweden, we have received the following:

Sten Brattström—Postoperative Pulmonary Ventilation with Reference to Postoperative Pulmonary Complications. Lund, 1954.

Olof Forssman—Myocardial Infarction and Adrenal Function. Lund, 1954.

Lars Martenson—A Study in Spinal Tuberculosis in Childhood. Copenhagen, 1954.

Inga Marie Nilsson—Demonstration of a Heparin-like Anticoagulant in Normal Blood. Lund, 1954. Anders Wenckert—The Activation of Prothrombin. Investigation of the Mode of Action of Human Brain Thromboplastin and of Russell Viper Venom. Stockholm, 1955.

109TH ANNUAL MEETING

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